

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10568

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 22 days  
Hospital, institution, or street address where death occurred:  
U S Naval Hospital, Bethesda, Maryland  
How long in hospital or institution? 22 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Virginia County  
City or town Richmond  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2824 Monument Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war World War I

### 3. (a) FULL NAME

BAKER, Maury Davison

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.

6. (b) Name of husband or wife Irene Dunne Baker

7. Birth date of deceased (mo., day, yr.) 25 June 1872 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Year 76 Month 3 Day 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kentucky  
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business

12. Name Robert M Baker deceased

13. Birthplace Virginia

14. Maiden name Louise F Davison deceased

15. Birthplace Virginia

16. Informant Wife; Irene Dunne Baker

Address 2824 Monument Ave Richmond Va.

17. Burial Date thereof 10-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Virginia

18. Funeral director S. H. HINES W. A. S.

Address 2901 14th St NW Washington D.C.

19. 10-10- 48 Marv C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 10 October 1948 at 9:58A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 September 1948, to 10 October 1948, and that I last saw him alive on 10 October 1948

Immediate cause of death Hemorrhage subdural & meningeal

Due to arteriosclerosis generalized

Due to

Other conditions Pneumonia lobar

(Include pregnancy within 3 months of death)

Major findings of operations

Transurethral resection Date of op. 9-27-48

Antopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

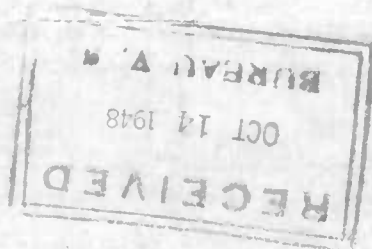
23. SIGNATURE P. L. BATES LTJG MC USN  
M. D. or other

Address U S NAVAL HOSPITAL Bethesda Md Date signed 10-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

10569

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? Dead on arrival

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Washington  
(If outside city or town limits, write RURAL and give nearest town)  
City or town Washington, D.C.  
Street No. 4400 Jennifer St. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Miss Mary Barbieri

## 3. (b) Social Security Number

4. Sex

Female white

5. Color or race

6. (a) Single, married, widowed, or divorced

single

8. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Sept. 17, 1914-

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

3418

hrs.

min.

9. Birthplace

Montpelier, Vt.  
(town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

MOTHER  
FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 5, 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sep med. Exam case  
and that I last saw him alive on.....19.....

Immediate cause of death

Hemorrhage due to  
internal injuries  
crushing pelvis  
accidental

DURATION

5 min.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide, accident Date of 10-5-48Where did injury occur? Washington (City or town) D.C. (State)Injured at home, farm, industry, public place, (where?) streetMeans of injury struck by bus Injured at work? no

23. SIGNATURE

Frank J. Broschart M.D.  
1st med exam M. D. or other  
Address Washington, D.C. Date signed 10-5-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

10570

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10-22-48  
Hospital, institution, or street address where death occurred: Suburban Hosp.  
8600 Old Georgetown Rd. - Bethesda Md.How long in hospital or institution? 10-22-48

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 4708 Ch. Ch. Blvd.  
(If rural, give LOCATION)2.(a) If veteran, name war No

## 3. (a) FULL NAME

Mr Rutland D. Beard

## 3. (b) Social Security Number

None4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife IRENE Beard7. Birth date of deceased (mo., day, yr.) March 29, 18756. (c) If alive, give age 51 years8. AGE: Years 73 Months 73 Days 6 If less than one day 24 hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Chief of Deportation

11. Industry or business

12. Name Thomas Beard13. Birthplace Davidsonville Md.14. Maiden name Martha Woodward15. Birthplace Davidsonville Md.16. Informant Irene S.I. BeardAddress 4708 Chevy Chase Blvd, Ch. Ch. Md.17. Burial Date thereof Oct. 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery Baldwin Memorial ChurchLocation Millersville, Maryland18. Funeral director Wm. Lawrence RingerAddress Bethesda, Maryland19. Oct. 25 19 48  
(Date rec'd by registrar)Registrar W.E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 19 48 at 10:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 19 48 to Oct 23 19 48and that I last saw him alive on Oct 23 19 48Immediate cause of death Asthma, BronchialDURATION 2 MonthDue to suburban cause

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

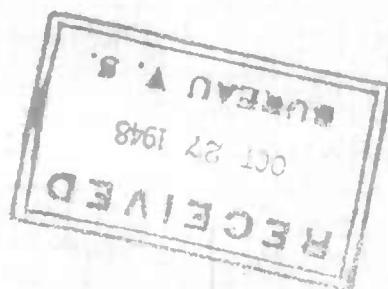
23. SIGNATURE Bradley D. Hopkins MDAddress 313 W. Butler Lane Date signed 10/23/48

M. D. or other

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10571

Reg. Dist. No. 215

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, (mural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 hr.  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 1 hr.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4032 2nd St., S.W.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWI & II

### 3. (a) FULL NAME

BISSON, Fred Joseph

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Elizabeth Bisson

7. Birth date of deceased (mo., day, yr.) September 18, 1892 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 56 Months 0 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Canada  
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business \_\_\_\_\_

12. Name BISSON, Joseph dec

13. Birthplace Canada

14. Maiden name BRULE, Mary Louise dec

15. Birthplace Canada

16. Informant wife: Mrs. Elizabeth Bisson

Address 4032 2nd St., S.W., Wash., D.C.

17. burial Date thereof 10-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS Donald Connor

Address 517 11th St., S. W., Wash., D.C.

19. 10-1 19-48  
(Date rec'd by registrar) Mary C. Patterson Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1 October 19 48 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 October 19 48 to 1 October 19 48 and that I last saw him alive on 1 October 19 48

Immediate cause of death Coronary thrombosis DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions slight stroke  
or cerebral lobe  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

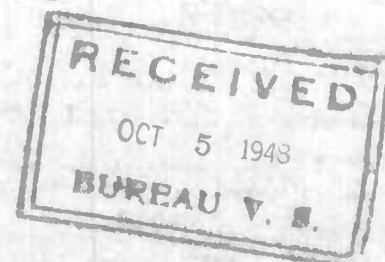
23. SIGNATURE P. L. BATES, Lt. JG MC USN  
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 10-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10572

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital, Old Geo. Rd.

How long in hospital or institution?

BETH

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Montg.City or town Derwood, R.F.D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rolland

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Infant (Male) Bittingen

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 30, 1948

## 8. AGE:

Years

Months

Days

If less than one day

11 hrs.40 min.9. Birthplace Bethesda, Montgomery, Maryland  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## FATHER

12. Name

Emmett Foster Bittingen

## MOTHER

13. Birthplace

Jordan Run, West Virginia

14. Maiden name

Foster M.A. Sandis

15. Birthplace

Tampa, Florida

## 16. Informant

Emmett Foster Bittingen

Address

Derwood, Maryland

## 17. (Burial, cremation, or removal, Which?)

Cremation

Date thereof

10-4-48

## Cemetery or crematory

Suburban Hospital

## Location

Bethesda, MD

## 18. Funeral director

A.B. Selmon, Supr

Address

Bethesda, md.19. 10-419 48

(Date rec'd by registrar)

W.E. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 - 1948 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 30 1948 to Oct. 1 1948and that I last saw him alive on Oct. 1 1948

Immediate cause of death

PrematurityEclampsia in mother

Due to

Due to

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State) .....

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE J. R. Smith, M.D.Rockville, Md. M. D. or otherDate signed 10/1/48

Address

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 7 1949  
BUREAU V. 8





RECEIVED

OCT 22 1948

BUREAU V. S.

I



Foroner notified and approved

11/2/48

Bureau of Vital Statistics

Dr. H. King Shirley did not see this child until after death.

The child was under the care of

Dr. Bernard Walsh Farragut Medical Bldg., Washington, D.C..

E. P. Thompson

Dr. Shirley could not add anything to the cause of death.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10575

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 22 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State N. C. County Roxboro  
 City or town Roxboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 221 N. Main St.  
 (If rural, give LOCATION)  
 2.(a) Is veteran, name war WWII ✓

## 3. (a) FULL NAME

CARLTON, Luther Montrose

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife  
 6. (c) If alive, give age years  
 7. Birth data of deceased (mo., day, yr.) April 30, 1912  
 8. AGE: Years 36 Months 6 Days 1 If less than one day hrs. min.

9. Birthplace N.C.  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business  
 12. Name CARLTON, Luther M. Sr. dec.  
 13. Birthplace N.C.  
 14. Maiden name HINES, Mary  
 15. Birthplace N.C.

16. Informant mother: Mrs. Mary H. Carlton  
 Address 221 N. Main St., Roxboro, N.C.  
 17. burial Removal Date thereof Nov. 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Birchwood Cemetery  
 Location Roxboro, N. C.  
 18. Funeral director W. W. Chambers  
 Address 1400 Chapin St., N. W., Wash., D.C.  
 19. 10-31-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 19 48 at 8:08 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 August 19 48 to 31 October 19 48  
 and that I last saw him alive on 31 October 19 48  
 Immediate cause of death Acute Congestive Heart Failure  
 Due to Endocarditis Subacute Bacterial DURATION 10 Mo.  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
W. F. Queen  
Wm. F. QUEEN, Cdr. MC USN  
 23. SIGNATURE M. D. or other  
 Address USNH Bethesda, Md. Date signed 10-31-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **215**

10578

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 mo. 19 days  
Hospital, institution, or street address where death occurred:  
U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND  
How long in hospital or institution? 5 Mo. 19 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District of Columbia  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2700 Q St. NW Apt 317  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

CARSON, Barbara (n)

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John Carson

8. (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) 15 February 1895

8. AGE: Years 53 Months 7 Days 23 If less than one day hrs. min.

9. Birthplace Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John Spencer deceased

13. Birthplace Virginia

14. Maiden name Ann Clark deceased

15. Birthplace Virginia

16. Informant Husband: John Carson, Apt. #317

Address 2700 Q St. N.W. Washington, D.C.

17. Burial Date thereof 9 October 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia

18. Funeral director Joseph Gawler Sons

Address 1756 Penn. Ave S.E. Washington D.C.

19. 10-8- 1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 8 October 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 April 1949 to 8 October 1948  
and that I last saw her alive on 8 October 1948

Immediate cause of death Carcinomatosis; Carcinoma  
left mammary gland.

DURATION  
May 48

Due to Left Radical mastectomy - Dec. 1945

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Papostel biopsy June 4, 1948  
Laminectomy - May 23, 1948 Date of op. 1/23/48 95

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Walter F. Harrison Jr Injured at work?

Walter F Harrison Jr IAT MC USN

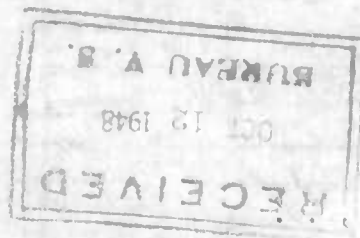
23. SIGNATURE U.S. Naval Hospital M. D. or other  
Address Bethesda, Md Date signed 10-8-38

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 514

10576

## 1. PLACE OF DEATH:

County... *Montgomery*  
 City or town... *Silver Spring*  
 (If outside city or town limits write RURAL and give near-at town)  
 How long in above place of death? *20 yrs*  
 Hospital, institution, or street address where death occurred:  
*8430 Piney Branch Court*  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

For born infants give residence of mother  
 State... *Maryland* County... *Montg*  
 City or town... *Silver Spring*  
 (If outside city or town limits write RURAL and give nearest town)  
 Street No. *8430 Piney Branch Court*  
 (If rural give LOCATION)  
 2.(a) If veteran name war...

## 3. (a) FULL NAME

*Earnest Wellener Carter*

## 3. (b) Social Security Number

*578-40-1366*

4. Sex *m* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced *married*

8. (b) Name of husband or wife... *Annie C. Carter*7. Birth date of deceased (mo., day, yr.) *Dec 4 1898* 6. (c) If alive, give age... years

8. AGE: Year *49* Months *28* Days *20* If less than one day  
 hrs. min.

9. Birthplace... *Baltes. Md*  
(Town, county, and state)10. Usual occupation... *Printer*11. Industry or business... *Gov.*12. Name... *Earnest Carter*13. Birthplace... *Eng.*14. Maiden name... *Annie S. Wellener*15. Birthplace... *Md.*16. Informant... *Alfred W. Womble*Address... *423 Pershing Dr. Silver Spring*17. *Burial* Date thereof... *Oct. 28, 1948*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... *Arlington Hall Cemetery*Location... *Arlington Va*18. Funeral director... *H. W. Chambers & Co.*Address... *1400 - Chapin St. NW*19. *Oct 24* 19 *48* *Josephine M. Schaeffer*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *Oct 24* 19 *48* at *1:57 A M*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sep med Exam case* 19 *48*and that I last saw him alive on *Sep med Exam case* 19 *48*

Immediate cause of death

*Coronary occlusion*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Meane of injury Injured at work?

23. SIGNATURE *Frank J. Burchard M.D.* M. D. or otherAddress *Yantraling Md* Date signed *10-24-48*



Oct 28, 1948

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Barnstown Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 1/2 daysHospital, institution, or street address where death occurred  
Suburban Hospital 6700 OldHow long in hospital or institution? 7 1/2 days

## 3. (a) FULL NAME

Mrs. Rosa L. Carter

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Robert L. Carter6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) Mar 9 - 1874

8. AGE: Years Months Days If less than one day

74615710

min.

9. Birthplace VIRGINIA

(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

12. Name SHE WAS AN ORPHAN

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Mr. daughter Chas RobertAddress Barnstown Md.17. Burial Date thereof 10-25-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Barnstown Md.Location Barnstown Md.18. Funeral Director GARDNERAddress Gettersburg Md.19. Oct 25 1948 Alfred G. Cook

(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Barnstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948, at 7:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 16 1948, to Oct 24 1948and that I last saw him alive on Oct 23 1948Immediate cause of death pneumonia 4 days DURATIONDue to intestinal obstruction 3 daysDue to gallstone impacted 3 daysin small intestineOther conditions surgery on 10-19-48

(Include pregnancy within 3 months of death)

Major findings of operations gallstone (HUGE)obstructing intestine Date of op. 10-19-48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. B. Phelan M. D. or other \_\_\_\_\_Address Bethesda Md. Date signed 10-24-48

10577

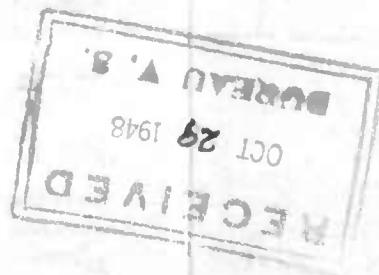
126

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? six months, four days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 6 mons. 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State D.C. County Washington  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5504 8th St., N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war WWI

### 3. (a) FULL NAME

CERELLO, Alexander (n)

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced  
single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 2 November 1890 6. (c) If alive, give age years

8. AGE: Years 57 Months 11 Days 0 If less than one day  
hrs. min.

9. Birthplace Italy  
(Town, county, and state)

10. Usual occupation Multilith Operator

11. Industry or business US Government

12. Name unknown

13. Birthplace unknown

14. Maiden name unknown

15. Birthplace unknown

16. Informant friend: Mr. Orlando Grassi

Address 5504 8th St., N. W., Wash., D.C.

17. burial Date thereof 10-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Virginia, Wash., D.C.

W.W. Chambers

19. Funeral director

Address 1400 Chapin St. N.W.

19. 10-2- 1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2 October 19 48 at 10:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
28 March 19 48 to 2 October 19 48  
and that I last saw him alive on 2 October 19 48

Immediate cause of death Hypertensive Heart Disease DURATION 24 hrs.

Due to Hypertensive arterial 12 yrs.

Due to

Other conditions Bronchopneumonia  
+ Pyelonephritis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Berry Lt. JG MC USN  
M. D. or other

Address USNH Bethesda, Md. Date signed 10-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10579

RECEIVED

OCT 5 1948

BUREAU V. S.



Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

10580

FILE No. G 117 OCT 19 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery  
City or town Pasadena  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6  
Hospital, institution, or street address where death occurred:  
Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Pasadena  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route no 119  
(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Ira milvillian Clothier

3. (b) Social Security Number

4. Sex 7 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife James Scott Clothier  
6. (c) If alive, give age 29 years  
7. Birth date of deceased (mo., day, yr.) 27 November 1858

8. AGE: Tears 90 Months 10 Days 48 If less than one day  
hrs. min.

9. Birthplace Marshall Virginia  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Daniel Stephenson  
13. Birthplace Front Royal Virginia

14. Maiden name Milvillian Palmer  
15. Birthplace Frankfort Indiana

16. Informant B. Clorencia I. Clothier  
Address Pasadena, Md.

17. Burial Date thereof 10-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Marshall Cem.

Location Marshall, Va.

18. Funeral director Wm. B. Hilton

Address Barnesville, Md.

19. 10/11 1948. Charles E. Egan  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 October 1948 at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
29 September 1948 to 10 Oct. 1948  
and that I last saw him alive on 9 October 1948

Immediate cause of death

DURATION

Hypostatic pneumonia

24 hours

Due to Cona

48 hours

Due to circulatory failure

10 years

arteriosclerosis

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Fawcett M.D.

M. D. or other

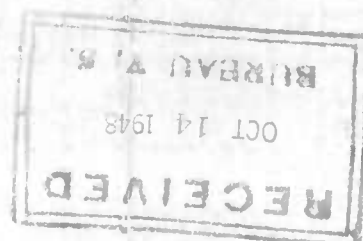
Address P.O. Baydo Md Date signed 10 Oct. 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10581

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 26 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 26 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 483 L St., S.W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Sp.Am. ✓

## 3. (a) FULL NAME

CRAIG, Charles

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col- 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Hattie Craig  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) ? ? 1875  
 8. AGE: Years 73 Months / ? Days ? If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation unemployed

## 11. Industry or business

FATHER  
 12. Name CRAIG, Alec dec.  
 13. Birthplace Va.  
 MOTHER  
 14. Maiden name unknown dec.  
 15. Birthplace Va.

16. Informant wife: Mrs. Hattie Craig  
 Address 483 L St., S.W., Wash., D.C.

17. burial Date thereof 9-25-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.

18. Funeral director John T. Rhines & Co.  
 Address 901 3rd St., S.W., Wash., D.C.

19. 10-21 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 October 1948 at 3:20 AM  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
25 August 1948 to 21 October 1948  
 and that I last saw him alive on 21 October 1948

Immediate cause of death  
Tuberculosis, Pulmonary, Active  
Far Advanced

## DURATION

5 yrs.

Due to Generalized Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

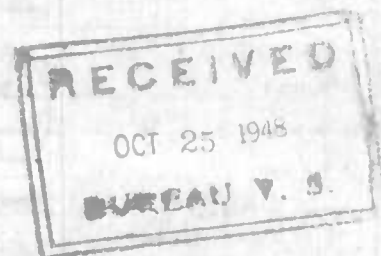
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE S. R. MILLS, Jr., Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 10-21-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10582

223

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Thrs 3 min

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? Thrs 3 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County D. C.City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 301 West Clifton Ter., 14th + Clifton Sts. N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war. ....

## 3. (a) FULL NAME

Mrs Elizabeth V. Davis

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

cauc.

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Henry W. Davis

7. Birth date of deceased (mo., day, yr.)

May 28, 18938.(c) If alive, give age 54 years

8. AGE:

Years

Months

Days

If less than one day

5541319 hrs.18 min.9. Birthplace Lynchburg, Virginia  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John F. Younger13. Birthplace Virginia14. Maiden name Minnie C. North15. Birthplace Virginia16. Informant Hospital RecordsAddress Washington Sanitarium & Hospital Takoma Park Md.17. Buried  
(Burial, cremation, or removal, Which?)

Date thereof

10/19/48  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address 2901 - 14th St. N.W.19. Oct 16 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1948 at 7:18 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct 15 1948 to Oct 15 1948and that I last saw her alive on Oct 15 1948

Immediate cause of death

Cerebral Hemorrhage turning

DURATION

Due to

Due to

Other conditions

Coronary DiseaseMonths

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Approved by Dr. Proffert, Capital, Mont. Co.

23. SIGNATURE

Robert A. Hare MD

M. D. or other

Address

Takoma Park, D.C.Date signed 10/15/48

RECEIVED

OCT 19 1948

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10583

## CERTIFICATE OF DEATH

Reg. Dist. No. 213

## 1. PLACE OF DEATH:

County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

FANNIE K. DAWSON

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Henry A. Dawson

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 3, 1869

## 8. AGE:

Years

Months

Days

If less than one day

781019

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

9. Birthplace Illinois

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home

## FATHER

12. Name John Williams13. Birthplace Maine

## MOTHER

14. Maiden name Frances Knight15. Birthplace England16. Informant Miss Rose DawsonAddress Rockville, Md.17. Burial Date thereof Oct. 24, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rockville CemeteryLocation Rockville, Md.18. Funeral director Waxner E. Pumphrey, Inc.Address Silver Spring, Md.19. Oct 23 19 48 Dr. E. P. Thompson  
(Date rec'd by registrar) Dr. E. P. Thompson

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 19 48 at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/9 19 47 to 10/22 19 48and that I last saw her alive on 10/22 19 48

## Immediate cause of death

Coronary Thrombosis

## DURATION

Due to Chronic MyocarditisDue to Arterio SclerosisOther conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

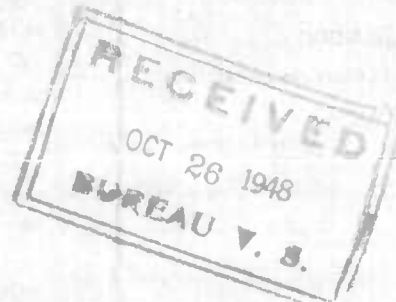
23. SIGNATURE C. E. Hawks M. D. or other \_\_\_\_\_Address Rockville Md Date signed 10/23/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10584

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3128 Oliver St., N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

DEICHLER, William Harrison

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Myrtle Deichler

7. Birth date of deceased (mo., day, yr.) April 10, 1891  
 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 57 Months 6 Days 20  
 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ill.  
 (Town, county, and state)

10. Usual occupation Civil Service11. Industry or business Treasury Dept.12. Name DEICHLER, Wm. H. dec.13. Birthplace N.Y.14. Maiden name GROSJEAN, Mary dec.15. Birthplace Ill.16. Informant wife: Mrs. Myrtle DeichlerAddress 3128 Oliver St., N. W., Wash., D.C.

17. Burial Date thereof 11-2-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Virginia18. Funeral director S. H. HINES S. H. Hines Co.Address 2901 14th St NW, Washington, D.C.

19. 10-30 19 48  
 (Date rec'd by Registrar) Registrar Mary C. Patterson

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 30 October 19 48 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 October 19 48 to 30 October 19 48

and that I last saw him alive on 30 October 19 48

Immediate cause of death Uremia

Due to Nephritis, Chronic

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. F. Queen  
Wm. F. QUEEN, Cdr. MC USN  
 M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 10-30-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10585

215

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....Montgomery  
 City or town.....Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....3 mons., 27 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?.....3 mons., 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D.C. County.....  
 City or town.....Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....1218 Walter Place, S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....Sp. Am. WAR

## 3. (a) FULL NAME

DENT, Addison

## 3. (b) Social Security Number

4. Sex.....male 5. Color or race.....Col. 6.(a) Single, married, widowed, or divorced.....married  
 8.(b) Name of husband or wife.....Ella Dent  
 8.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....December 4, 1864  
 8. AGE: Years.....83 Months.....10 Days.....1 If less than one day..... hrs. .... min.

9. Birthplace.....Maryland  
 (Town, county, and state)  
 10. Usual occupation.....Helper - Navy Yard, Wash., D.C.  
 11. Industry or business.....  
 12. Name.....DENT, Henry dec.  
 13. Birthplace.....Md.  
 14. Maiden name.....Julie ? dec.  
 15. Birthplace.....Md.

16. Informant.....Mrs. Ella Dent, wife  
 Address.....1218 Walter Pl., S.E., Wash., D.C.  
 17. burial Date thereof.....Oct. 11, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....Arlington National  
 Location.....Arlington, Va.  
 18. Funeral director.....Geo. A. Better & Sons  
 Address.....1203 Walter Pl., S.E., Wash., D.C.  
 19. 10-5 10-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....5 October 1948 at 10:15A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8 June 1948 to 5 October 1948  
 and that I last saw him alive on 5 October 1948

## Immediate cause of death

Carcinoma Prostate with metastasis

## DURATION

unknown

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

## 23. SIGNATURE

R. L. FLECK, Lt MC USN

M. D. or other

Address.....USNH Bethesda, Md. Date signed.....10-5-48

RECEIVED

OCT 8 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County MontgomeryCity or town Olney  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 daysHospital, institution, or street address where death occurred Montgomery Co. Gen HospHow long in hospital or institution? 20 days

## 3. (a) FULL NAME

Mingo J. Dickinson

## 3. (b) Social Security Number

215-14-7194

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Phoebe Dickinson6. (c) If alive, give age 3 years

## 7. Birth date of deceased (mo., day, yr.)

Aug 5 1876

## 8. AGE:

Years

72

Months

3

Days

6

If less than one day

— hrs. — min.

## 9. Birthplace

Prin.

(Town, county, and state)

## 10. Usual occupation

Retired

## 11. Industry or business

Parkway Electric

## MOTHER

## FATHER

## 12. Name

Lewis S. Dickinson

## 13. Birthplace

New York

## 14. Maiden name

Isabella Arnold

## 15. Birthplace

New York

## 16. Informant

Olney

## Address

Wheaton Md

## 17. Burial

Date thereof

Oct. 12, 48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Cedar Hill

## Location

Suitland, Maryland.

## 18. Funeral director

Warner E. Humphrey, Inc.

## Address

8434 Ga. Ave. Silver Spring, Md.

## 19. J.C.F. 15

(Date rec'd by registrar)

19 48Estelle B. Lander

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Wheaton Hills,  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11,801 Georgia Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/ 19 48 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/20/ 19 48 to 10/9/ 19 48and that I last saw him alive on 10/9/ 19 48Immediate cause of death Myocardial

## DURATION

1 hr

Due to

Chronic Interstitial Nephritis

Due to

Other conditions

Hypertensive Heart

(Include pregnancy within 8 months of death)

Major findings of operations

Reoperation for drainage of kidneys Date of op. 9/28/48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —

23. SIGNATURE

Sandy E. King M.D. or other no Date signed 10/10/48

RECEIVED

OCT 20 1943

BUREAU V. P.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 10587  
216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

7724 Aberdeen Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7724 Aberdeen Rd.

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME -

Francis Asbury Dory

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Charlotte Barr7. Birth date of deceased (mo., day, yr.) 14 Feb 18766. (c) If alive, give age 70 years8. AGE: Years 72 Months 8 Days 12 If less than one day  
.....hrs. ....min.9. Birthplace Millard Penna.  
(Town, county, and state)10. Usual occupation Engrossing artist for Govt.11. Industry or business Post Office Printing Div.12. Name James H. Dory13. Birthplace Penna.14. Maiden name Charlotte Clark15. Birthplace Nebraska16. Informant DanielAddress 7724 Aberdeen Rd. Bethesda Md.17. (Burial, cremation, or removal, which?) Burial Date thereof Oct 25-48  
(month) (day) (year)Cemetery or crematory WashingtonLocation Washington18. Funeral director Arthur S. Sammons Jr.Address 2117 Nichols Ave S.E.19. Oct 27, 1948 H.M.C. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Oct 1948 at 9:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Oct 1948 to 26 Oct 1948and that I last saw him alive on 25 Oct 1948Immediate cause of death Carcinoma of ProstateTuberculosisDue to Melateria from Melateriaif Carcinoma has metastasizedDue to to liver & other organs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Prostateinoperable Date of op. Oct 1944

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE John G. Ball M.D. M. D. or otherAddress 7931 Georgetown Rd Date signed 26 Oct 48  
Bethesda Md



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10588

1224

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 603 Virginia Avenue, S. E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI ☒

## 3. (a) FULL NAME

DORSEY, Clarence Odin

## 3. (b) Social Security Number

4. Sex male 5. Color or race Col 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, gives age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) December 7, 1895  
 8. AGE: Years 52 Months 10 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 8:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
22 October 1948 to 24 October 1948  
 and that I last saw him alive on 24 October 1948

Immediate cause of death Shock

DURATION

48 hrs.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Handy Man  
 11. Industry or business \_\_\_\_\_  
 12. Name DORSEY, James dec.  
 13. Birthplace Md.  
 14. Maiden name ODIN, Harriett dec.  
 15. Birthplace Md.

Dus to intestinal obstructionDus to volvulusOther conditions Branch pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results volvulus intestinal obstruction  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

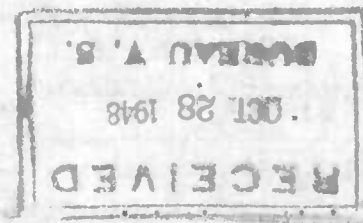
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

16. Informant sister: Mrs. Helen Scott  
 Address 5352 1/2 Gall Place, S.E., Wash., D.C.  
 17. burial Date thereof 10-29-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. Ernest Jarvis  
 Address 1432 U St.; N. W., Wash., D.C.  
 19. 10-26 1948 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

23. SIGNATURE D. E. BILLMAN, Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 10-26-48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10589

Reg. Dist. No. 215

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 9 hours  
Hospital, institution, or street address where death occurred:  
U S NAVAL HOSPITAL  
How long in hospital or institution? 9 hours

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District Columbia County  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3024 Alabama Ave S E Washington DC  
(If rural, give LOCATION)  
2.(a) If veteran, name war World War One

### 3. (a) FULL NAME

ECKLEY, Ra ymond (n)

### 3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1888 B.(c) If alive, give age years

8. AGE: Years 60 Months 6 Days 13 If less than one day  
..... hr. .... min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Jack Eckley deceased

13. Birthplace PENNSYLVANIA

14. Maiden name Lizzie Reese deceased

15. Birthplace PENNSYLVANIA

16. Informant SISTER: Mrs Eddie Sanders

Address 3024 Alabama Ave S.E. WASHINGTON

17. Burial Date thereof 10-13-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Virginia

18. Funeral director W.W. Chambers

Address 517 11th St S E Washington D C

19. 10-10-48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9 October 19 48 at 9:53 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
9 October 19 48 to 9 October 19 48  
and that I last saw him alive on 9 October 19 48

Immediate cause of death Hepatitis, Acute DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Dele of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? City or town County State

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. A. Dinsmore, Jr. LCDR MC USN  
M. D. or other

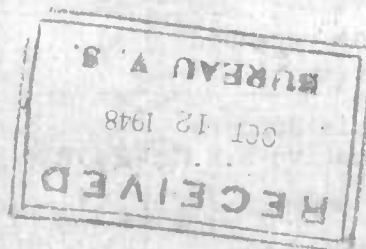
Address US NAVAL HOSPITAL Bethesda Md Date signed 10-10-48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1948-12-9  
66-6-13  
1988-3-26





Reg. Dist. No. 214

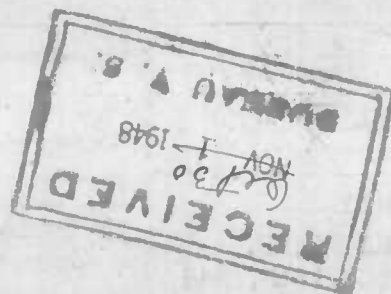
621 Maryland Ave, N.E. Date signed 10-13-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10591

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

74

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. (Burial, cremation, or removal. When?)

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar)

19. 48

Gertrude B. Lawler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec 10

19. 48

at ?

P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sep med exam case 19 to 19 and that I last saw h..... alive on 19

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 10-12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7681  
76  
8761

RECEIVED

OCT 20 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
7814 Stratford Rd.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7814 Stratford Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Wilbur Wesley Gantz

### 3. (b) Social Security Number

216-05-7553

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Juliet G. Gantz

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1892

8. AGE: Years Months Days If less than one day  
56 2 26 hrs. min.

9. Birthplace Harrisburg, Ohio  
(Town, county, and state)

10. Usual occupation Dodge & Plymouth Auto Dealer

11. Industry or business

Joseph M. Gantz

12. Name Harrisburg, Ohio

13. Birthplace Lydia Chenoweth

14. Maiden name Harrisburg, Ohio

15. Birthplace

18. Informant Mrs Juliet G. Gantz

Address 7814 Stratford Rd., Bethesda, Md.

17. Cremation Date thereof Oct. 11, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Maryland

18. Funeral director Warner E. Pumphrey, Inc.

Address 8434 Ga. Ave. Silver Spring, Md.

19. 10-10 48 W. E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948 7:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 21 1947 to OCTOBER 8 1948  
and that I last saw him alive on OCTOBER 8 1948

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

1.6 hours

Due to HYPERTENSION, ARTERIAL

9 MONTHS

Due to NEPHROSCLEROSIS,  
MALIGNANT

9 MONTHS

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert G. Angle M.D.  
M. D. or other  
Address 106 Del Ray Ave. Bethesda Date signed Oct 9, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10592



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10593

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town WHEATON, MD.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yearHospital, institution, or street address where death occurred:  
11703 GRANDVIEW AVE.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County MONTGOMERYCity or town WHEATON  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11703 GRANDVIEW AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

LILIAN MARIAN Green

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

FEMALE White WIDOWED6. (b) Name of husband or wife ARTHUR W. GREEN

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 18738. AGE: Years 75 Months 4 Days 14 If less than one day hrs. min.9. Birthplace Kentucky  
(Town, county, and state)10. Usual occupation AT HOME

## 11. Industry or business

12. Name HENRY NICHOLAS RAVENSBURG13. Birthplace GERMANY14. Maiden name JENNIE HILTERMANN15. Birthplace GERMANY16. Informant ARTHUR W. GREEN (SON)Address 11703 GRANDVIEW AVE. WHEATON, MD.17. CREMATION Date thereof OCT. 18, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CEDAR HILLLocation SMITHLAND, MD.18. Funeral director Joseph Dandley's Sons, Inc.Address 1756 Pa. Ave. N.W. Wash. 6, D.C.19. Oct 17 1948 Joseph Dandley's Sons, Inc.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17th 1948 at 7:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1948 to Oct. 17 1948  
and that I last saw her alive on Oct. 15 1948Immediate cause of death Coronary Occlusion DURATION 3 daysDue to Coronary Occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sam. R. Hoffman M. D. or otherAddress 1912 - RST L.A. 26 Date signed 10-17-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 15 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 15 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3948 Garrison Avenue, N. W.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

GROSEBECK, Bertram

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 8. (b) Name of husband or wife Mrs. Bertram Grosebeck  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) December 17, 1870  
 8. AGE: Year 77 Month 10 Day 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace New York  
 (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business \_\_\_\_\_

FATHER  
 12. Name GROSEBECK, Abraham N. dec.  
 13. Birthplace N.J.  
 MOTHER  
 14. Maiden name ACKERMAN, Mary dec.  
 15. Birthplace N.J.

16. Informant Son: R. Adm. Bertram Grosebeck, USN  
 Address 3948 Garrison Ave., N.W., Wash., D.C.

17. ~~Burial~~ Cremation Date thereof 10-20-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Cedar Hill Cem.  
 Cemetery or cremator Inter. Rock Creek Cemetery  
 Location Washington, D.C.

18. Funeral director PUMPHREY Funeral Home  
 Address 7557 Wisconsin Ave., Bethesda, Md.

19. 10-18 19 48 Mary C. Patterson  
 (Date rec'd by registrar) (Year) (Month) (Day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 October 19 48 at 11:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
2 August 19 48 to 17 October 19 48  
 and that I last saw him alive on 17 October 19 48

Immediate cause of death Chronic Myeloid Leukemia  
 DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury 2. Lane Injured at work? \_\_\_\_\_23. SIGNATURE F. R. LANG, Capt. MC USN M. D. or other \_\_\_\_\_Address US Naval Hosp., Bethesda, Md. Date signed 10-18-48

10594

742

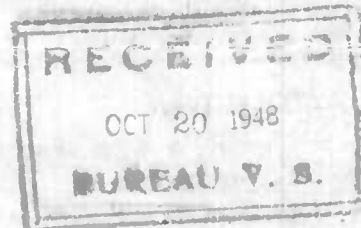
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED BY THE UNITED STATES DEPARTMENT OF JUSTICE

M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

10595

Reg. Dist. No. 223-

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 days - 9 hrs.  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium and Hosp.  
 How long in hospital or institution? 15 days - 9 hrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1549 N. Falkland Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ?

## 3. (a) FULL NAME

Gross John Mr.

## 3. (b) Social Security Number

4. Sex M 5. Color or race Cauc. 6. (a) Single, married, widowed, or divorced Widower.

6. (b) Name of husband or wife Bertha Gross

7. Birth date of deceased (mo., day, yr.) June 25, 1869

8. AGE: Years 79 Months 4 Days no If less than one day — hrs. — min.

9. Birthplace Carrington Ohio.  
 (Town, county, and state)

10. Usual occupation Retired - Capt. of Police Dept.

11. Industry or business Pittsburg.

12. Name Jacob Gross.

13. Birthplace Pennsylvania.

14. Maiden name Elizabeth Fahnstock

15. Birthplace Ohio.

16. Informant Sanitarium Records and Daughter

Address 1549 N. Falkland Lane Silver Spring

17. Burial Date thereof Oct 28 - 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Carrington Cem.

Location Carrington Ohio

18. Funeral director Warner E. Humphrey Inc.

Address 8434 Georgia Ave. Pk. Md.

Oct 25 - 48

19. (Date rec'd by registrar) 1948

Registrar J. M. M. M.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1948 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 10 1948 to Oct 24 1948  
 and that I last saw him alive on Oct 24 1948

Immediate cause of death Coronary Arteriosclerosis  
pt. Arterial Arteriosclerosis  
Terminal pneumonia  
Pylonephritis

## DURATION

1 day  
3 days  
2 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

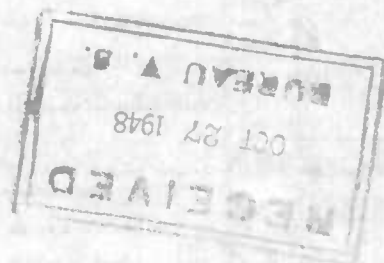
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. K. M. M. M.

M. D. or other

Address Takoma Park, Md. Date signed 10-25-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH

County Montgomery  
 City or town Selma, Barnesville, Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Montgomery County Montgomery  
 City or town Selma, Barnesville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles A. Hallman

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

Aug. 17, 1888

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

It less than one day

60

hrs.

min.

## 9. Birthplace

Barnesville, Md  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

## MOTHER FATHER

## 12. Name

James H. Hallman

## 13. Birthplace

Montgomery

## 14. Maiden name

Elizabeth Holmes

## 15. Birthplace

Montgomery

## 16. Informant

Mrs Lucy Smith (Daughter)

## Address

Rockville, Md

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

## Cemetery or crematory

Selma

## Location

Barnesville, Md

## 18. Funeral director

Robert L. Snowden

## Address

Rockville, Md

## 19.

(Date rec'd by registrar)

October 21, 1948Mrs. C. C. Hilton  
By Mrs. C. C. Hilton, Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Oct 18 1948 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam case to 19and that I last saw him alive on 19

Immediate cause of death

DURATION

Carcinoma of stomach 1 year

Due to

Found dead in bed

Due to

Reported to have been affected with  
in Hodgkin's lymphoma

Other conditions

May 20 C. A. of stomach  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Brorbeck M. D.  
Sept med exam  
Washington Md Date signed 10-19-48

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

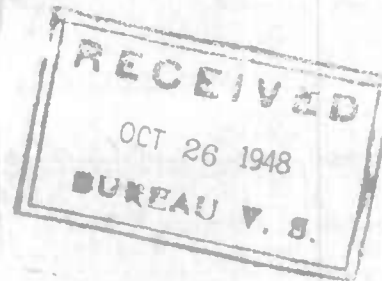
VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

468

10596





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

10597

## 1. PLACE OF DEATH

County MontgomeryCity or town Fairland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Briggs-Chaney Rd.How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Fairland  
(If outside city or town limits, write RURAL and give nearest town)Street No. Briggs-Chaney Rd.  
(If rural, give LOCATION)2. (a) If veteran, name war —

## 3. (a) FULL NAME

William J Harding

## 3. (b) Social Security Number

219-05-0105

4. Sex

M

5. Color or race

N

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Virginia Culver7. Birth date of deceased (mo., day, yr.) April 5, 18806. (c) If alive, give age — years8. AGE: Years 68 Months 6 Days 18 If less than one day  
..... hrs. .... min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Andrew J. Harding13. Birthplace Maryland14. Maiden name Margaret Myers15. Birthplace Maryland16. Informant Mrs Virginia C. HardingAddress Fairland, Maryland.17. Burial Date thereof Oct. 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Colesville Meth. ChurchLocation Colesville, Maryland.18. Funeral director Warner E. Humphrey, Inc.Address 8434 Ga. Ave. Silver Spring, Md.19. Oct 25 19 48 Josephine A. Chaffin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/1948 at 20 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/21 1947, to 10/23/1948 and that I last saw him alive on 10/22/1948Immediate cause of death Cerebral Hemorrhage DURATION 2 daysDue to Cardiovascular disease with Hypertension 2,Due to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Josephine A. Chaffin M. D. —Address Sandy Spring, Md. Date signed 10/24/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
OCT 28 1948  
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10598

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Beallsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Beallsville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Lee C

## 3. (b) Social Security Number

Harper

## 4. Sex

Male

## 5. Color or Race

Colored

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Annie Harper

## 7. Birth date of deceased (mo., day, yr.)

June 6, 1880

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

68 YearsMonths 4Days 4

If less than one day

hrs. \_\_\_\_\_ min. \_\_\_\_\_

## 9. Birthplace

Maryland  
(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

MOTHER FATHER

## 12. Name

Columbus Harper

## 13. Birthplace

md.

## 14. Maiden name

Rosie Lee

## 15. Birthplace

md.

## 16. Informant

Alfred Harper

## Address

Poolesville md

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof 10/13/48  
(month) (day) (year)

## Cemetery or crematory

Poolesville

## Location

Poolesville md

## 18. Funeral director

Clarence H. Davis

## Address

Poolesville md

## 19.

Oct. 13  
(Date rec'd by registrar)

## 19.

H. C. Chabert  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1948 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam case 1948 to 1948  
and that I last saw him alive on 1948

Immediate cause of death

Cerebral hemorrhage

Due to

hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Thos J. Brochart M.D.

Address

Yachting club  
Date signed 10-11-48

## DURATION

18 hrs.2 yrs.

**RECEIVED**

OCT 19 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

## 1. PLACE OF DEATH:

County MarylandCity or town Bethesda Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

45 - Populus Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County DCCity or town Washington D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 212 Hodge St.

(If rural, give LOCATION)

2(a) If veteran, name war

none

## 3. (a) FULL NAME

ELSIE HARRIS

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife Mr. Harris

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 30, 1870

8. AGE: Years Months Days If less than one day

78 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Winnipeg, Canada  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Samuel H. Durning13. Birthplace Canada14. Maiden name Charlotte Corbett15. Birthplace Canada16. Informant Mr. James A. GrayAddress 1706 Crest Wood drive N.W.17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1948

(month) (day) (year)

Cemetery or crematory Rock Creek CemeteryLocation Washington, D.C.18. Funeral director Wm. Lee's Sons Co.Address 300 - 4th N.E. Wash. D.C.19. (Date rec'd by registrar) Oct 15 48 Registrar Wm. Lee's Sons Co.

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1948 at 10:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2 1946 to 10-15 1948and that I last saw her alive on 10-15 1948

Immediate cause of death

Acute Cardiac Failure

DURATION

Due to hypostatic Congestionand generalized toxemia

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Dean H. Harding M.D.

M. D. or other

Address 113 Carroll St N.W.Date signed 10-15-48Washington D.C.

**RECEIVED**

OCT 19 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 22 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 1 month, 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D. C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1028 Conn Ave., N.W., LaSalle Apts.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

HAWK, Mary Townsend

## 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife George F. Hawk  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 13, 1870  
 8. AGE: Years 78 Months 3 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business \_\_\_\_\_  
 12. Name TOWNSEND, John G. dec. \_\_\_\_\_  
 13. Birthplace N.H.  
 14. Maiden name LONG, Margaret dec. \_\_\_\_\_  
 15. Birthplace Pa.

16. Informant Cousin: Mr. M. Riley  
 Address 1028 Conn Ave., LaSalle Apts., Wash., D.C.  
 17. burial Date thereof 11-1-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Freeport Cemetery  
 Location Freeport, Pa.  
 18. Funeral director Joseph Gawler Rk!  
 Address 1750 Pennsylvania Ave., N.W., Wash., D.C.  
 19. 10-26-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 October 1948 at 5:50 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 September 1948 to 25 October 1948  
 and that I last saw him alive on 25 October 1948  
 Immediate cause of death Miliary Tuberculosis DURATION 1 month  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Anxiety and  
asphyxia DURATION 1 month  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE E. M. Spaulding M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 10-26-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Info correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10601

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2nd dead  
 Hospital, institution, or street address where death occurred:  
Rock Run near Mrs Arthur Blood  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M. Maryland County Montg  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Persimmon Tree Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

John Walter Hinton

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) May 22nd, 1876

8. AGE: Years 72 Months 5 Days 6 If less than one day - hrs. - min.

9. Birthplace Montg. Co., Md.  
(City, county, and state)10. Usual occupation Gardener11. Industry or business None12. Name Jackson Hinton13. Birthplace Md. ?14. Maiden name Unknown15. Birthplace Unknown16. Informant Jacqueline HintonAddress Bethesda, Md.17. Burial Date thereof Nov. 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Herman Church CemeteryLocation Cabin John, Maryland18. Funeral director W. R. Reuther, BaltimoreAddress Bethesda, Md.

19. 11-4 19-76 W. E. Jacob  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1948 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19  
1st med exam case and that I last saw h. alive on 19

Immediate cause of death Coronary occlusion

## DURATION

Due to 1st med exam case

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following;

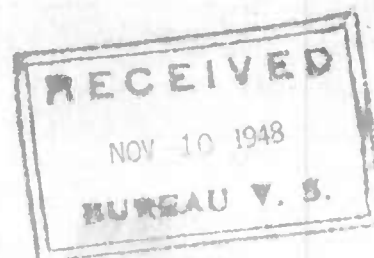
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Borschart M.D. M. D. or otherAddress Christiansburg Md Date signed 10-31-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6407 Meadow Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Cherry Chase  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6407 Meadow Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

HATTIE BELT INGERSON

## 3.(b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

William Biglow Ingersoll

7. Birth date of deceased (mo., day, yr.)

Oct. 18, 1881

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

671128

hrs.

min.

9. Birthplace

Beltville, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Samuel Rufus

13. Birthplace

Beltville, Md.

14. Maiden name

Mary S. Ryland

15. Birthplace

Baltimore, Md.

16. Informant

William Belt Ingersoll

Address

6407 Meadow Lane17. Burial

Date thereof

Oct. 18, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Perkins Chapel Cem.

Location

Springfield, Md.

18. Funeral director

The S. W. Jones Co.

Address

2901 14th St. N.W.19. 10-1619 48W.E. Jones

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 19 48 at 5:30 p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 319 48

to

Oct 1519 48and that I last saw him alive on Oct 15, 19 48

Immediate cause of death

General carcinomatosis

DURATION

? mos

Due to

Carcinoma of breast5 mos

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of breast  
beginning breast removal Date of op. May 6, 1948

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

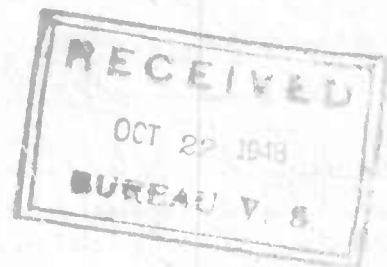
Injured at work?

23. SIGNATURE

John Hagan M.D.

M. D. or other

Address 6001 Kunder N.W. Date signed Oct 15 '48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10603

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash., D.C. County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. #1 9th St., S.E.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

IRWIN, John Glasgow

## 3. (b) Social Security Number

4. Sex male 5. Color or race White 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Germaine P. Irwin  
 7. Birth date of deceased (mo., day, yr.) August 14, 1889 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 59 Months 2 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Machinist  
 11. Industry or business \_\_\_\_\_  
 12. Name IRWIN, Eugene  
 13. Birthplace Pa.  
 14. Maiden name GLASGOW, Caroline  
 15. Birthplace Pa.

16. Informant Wife: Mrs. Germaine P. Irwin  
 Address #1 9th St., S.E., Wash., D.C.  
 17. burial Date thereof Nov 3, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Pleasant Hill Cemetery  
 Location Glasgow, Pa.  
 18. Funeral director Joseph Cawler & Sons  
 Address 1756 Pennsylvania Ave., N.W., Wash., D.C.  
 19. 10-31-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 19 48 at 3:05 P.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 October 19 48 to 31 October 19 48  
 and that I last saw him alive on 31 October 19 48

Immediate cause of death Thrombosis, Coronary Artery DURATION 48 hrs.

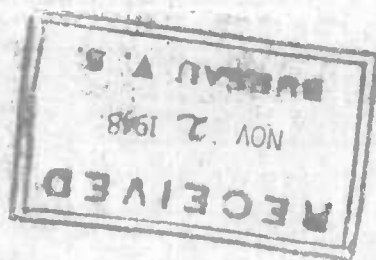
Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE Wm. F. Queen Wm. F. QUEEN, Cdr. MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 10-31-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County MontgomeryCity or town Sakoma Park  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:

45 Poplar Ave.How long in hospital or institution? 11 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County MontgomeryCity or town Sakoma Park  
(If outside city or town limits, write RURAL and give nearest town)Street No. 45 Poplar Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

GERDA JAKOBSSON

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Gustav Herman Jakobson

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 18708. AGE: Years 78 Months 7 Days 0 If less than one day  
hrs. min.9. Birthplace Sweden  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Unknown13. Birthplace Sweden14. Maiden name Unknown15. Birthplace Sweden16. Informant Mrs. Jane C. JohnsonAddress 14 Crescent Place, Sakoma Park, Md.17. Cremation Date thereof Oct. 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CrematoryLocation Ford & Penn Ave. S.E. Washington D.C.18. Funeral director J. Arthur WaltersAddress 2541 Sunrise St. Sakoma Park - Md.19. Oct. 3, 1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 October 1948 at 4:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 1946 to 1 Oct. 1948  
and that I last saw her alive on 30 Sept. 1948Immediate cause of death  
Coronary thrombosis

## DURATION

24 hrsDue to arteriosclerosis - generalized 10-12 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Quinn M.D.  
M. D. or otherAddress Sakoma Park, Md. Date signed 1 Oct 1948



**RECEIVED**

OCT 5 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

10605

y14

## 1. PLACE OF DEATH:

County.....Montgomery.....City or town.....Colesville Pike.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Mrs. Jolliffes Rest Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....D.C...... County.....City or town.....Washington, D.C......  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2422 - 39th Street N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....✓

## 3. (a) FULL NAME

HELEN R. JOHNSON

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....George C. Johnson.....

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

November 17, 1857

8. AGE:

Years

Months

Days

If less than one day

9010

hrs.

min.

9. Birthplace

Philadelphia, Penna.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Elwood Johnson

13. Birthplace

Philadelphia, Penna.

MOTHER

14. Maiden name

Mary E. Johnson

15. Birthplace

Penna.

18. Informant

Mr. Elwood Johnson

Address

2422-39th Street N.W., Wash.D.C.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....Oct 9, 1948.....

(month) (day) (year)

Cemetery or crematory

Location

Philadelphia, Pennsylvania

18. Funeral director

Martin W. Hysong Co.

Address

1300-N Street N.W., Washington, D.C.

19.

Oct 7  
(Date rec'd by registrar)

19

48Josephine Schaeffer  
Registrar

Register

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....OCTOBER.....7....., 1948..... at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June.....1944..... to.....Oct 7.....1948.....and that I last saw h. or alive on.....Oct 5.....1948.....

Immediate cause of death

Cerebral thrombosis

DURATION

8 da.

Due to

Cardiovascular revascularization4 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

E. E. Ruyle M.D.

M. D. or other

Address

1822 Belmont St. N.W.  
Date signed.....10/7/48.....

RECEIVED

OCT 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for correction  
of age shown on:

FILM No. G 117 OCT 28 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10606

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3124 Patterson Place N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Hopkins Jones

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mrs. Florie C. Jones

7. Birth date of deceased (mo., day, yr.) November 20, 1872

6. (c) If alive, give age 70 years

8. AGE: Years 75 Months 10 Days 22 If less than one day  
hrs. min.

9. Birthplace Brooksville, Montgomery Co. Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name William Jones

13. Birthplace Howard Co, Maryland

14. Maiden name Mary Ellen Parsley

15. Birthplace Brooksville, Md.

16. Informant Hospital record

Address

17. Burial Date thereof Oct 16 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Salon

Location Brooksville Md

18. Funeral director Ed W. Babin

Address St. Ann's

19. Oct 16 19 48 Gertrude B. Lawler  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH October 14 19 48 at 12 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1 19 47 to October 14 19 48  
and that I last saw him alive on October 14 19 48

Immediate cause of death Carcinomatous

DURATION

6 mos

Due to Carcinoma of Prostate 1 yr

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE J. B. L. M. D. or other

Address Sandy Spring, Md Date signed 10/14/48

RECEIVED

OCT 20 1948

BUREAU V. J.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10607

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

Female Colored married

6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....  
 11. Industry or business.....

12. Name.....  
 13. Birthplace.....

14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....

17. Date thereof.....  
 (month) (day) (year)

18. Location.....  
 19. Date rec'd by registrar.....

20. Registrar.....

21. Address.....

22. Date signed.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... at..... P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him/her alive on.....

Immediate cause of death.....  
 DURATION.....

Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....  
 Address..... Date signed.....

RECEIVED  
NOV 4 1948  
BUREAU A. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10608

Reg. Dist. No. 716

### 1. PLACE OF DEATH:

County... Montgomery  
City or town... Rockville Pike, Bethesda, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State... Maryland County... Montgomery  
City or town... Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4816 Bradley Blvd.  
(If rural, give LOCATION)  
2(a) If veteran, name war... No

### 3. (a) FULL NAME

Gertrude Quinlan Julien

### 3. (b) Social Security Number

4. Sex... Female 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Widowed

6. (b) Name of husband or wife... Joseph E. Julien

7. Birth date of deceased (mo., day, yr.)... July 19, 1873 6. (c) If alive, give age... dec. years

8. AGE: Year... 75 Months... 75 Days... 2 If less than one day... 19 hrs. min.

9. Birthplace... New York  
(Town, county, and state)

10. Usual occupation... Nurse

11. Industry or business

MOTHER FATHER 12. Name... Patrick Burns 13. Birthplace... Ireland

14. Maiden name... Emily Collins 15. Birthplace... New York

16. Informant... Wm. Allen Quinlan - Son  
Address... 7809 Old Chester Rd. - Bethesda, Md.

17. Burial... Greenwood Cemetery  
(Burial, cremation, or removal. Which?) Date thereof... October 11, 1948  
(month) (day) (year)  
Cemetery or crematory... Decatur, Ill.  
Location

18. Funeral director... Wm. Allen Quinlan  
Address... Bethesda 14, Maryland

19. 10-11 1948  
(Date rec'd by registrar) Registrar... W.E. Jones

### MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct 8 1948, at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 and that I last saw him... live on 19

Immediate cause of death... Fracture of skull (accidental) DURATION... killed instantly

Due to... auto injury

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... accident Date of Oct 8 - 1948  
Where did injury occur? Rockville Rd. Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)... highway

Means of injury... Struck by auto Injured at work? no

23. SIGNATURE... Frank J. Bronhart M.D. M. D. or other

Address... 10-8-48 Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

10609

1. PLACE OF DEATH: Montgomery  
 County.....Gaithersburg, MD.  
 City or town.....Six Months  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Montgomery  
 City or town.....Gaithersburg, MD.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....War (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Roland B. Kemp

3. (b) Social Security Number  
578 12 6551

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife.....Agnes M. Kemp

6.(c) If alive, give age.....55 years

7. Birth date of deceased (mo., day, yr.) Jan. 19 1895

8. AGE: Years 53 Months 9 Days 11 If less than one day  
 ....hrs. ....min.

9. Birthplace.....Maryland  
 (Town, county, and state)  
Carpenter

10. Usual occupation.....

11. Industry or business.....Building  
Samuel S. Kemp

12. Name.....

13. Birthplace.....Oakdale, MD.

14. Maiden name.....Elizabeth G. Welsh

15. Birthplace.....Maryland

16. Informant.....Agnes M. Kemp

Address.....2. Marshall Ave Gaithersburg, MD.

Burial Nov. 2. 1948

17. (Burial, cremation, or removal. Which?) Date thereof.....Hyatts Town MD.

Cemetery or crematory.....

Location.....Montgomery, CO

Roy W. Barber

18. Funeral director.....Laytonsville, MD.

Address.....

19. Nov. 1 1948 Abraham G. Code

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct. 30 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 23 1948 to October 30 1948  
 and that I last saw him alive on October 23 1948

Immediate cause of death.....Interosseptic cardio-vascular disease  
 DURATION  
3 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....James P. Kerr M.D.  
 M. D. or other

Address.....Montgomery, MD.

Date signed.....11/1/48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10610

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Near Cabin John  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Died Suddenly

Hospital, institution, or street address where death occurred:

Died in Auto at HomeHow long in hospital or institution? Died at Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 6612 Exfair Road  
(If rural, give LOCATION)2.(a) If veteran, name war World War II \* Army

## 3. (a) FULL NAME

BRYAN JOE Kitterman

## 3. (b) Social Security Number

568-03-9861

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Dorothy Mae Kitterman7. Birth date of deceased (mo., day, yr.) September 29, 1913

8. AGE: Years Months Days If less than one day

35 35 0 6 hrs. min.9. Birthplace Tulsa Oklahoma  
(Town, county, and state)10. Usual occupation Electrician-Model Basin11. Industry or business None12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Mrs. Dorothy Mae Kitterman (Wife)Address 639 Main Avenue, S.W. Wash. D.C.17. Burial Date thereof 10/5/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington National CemeteryLocation Arlington, Virginia18. Funeral director W. Reuben HumphreyAddress 7557 Wisconsin, Bethesda, Md.19. 10-4 48 W.E. Jobs  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 19 XV at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1948 exam case 19 to 19 and that I last saw h. alive on 19

Immediate cause of death

AsphyxiaDue to Carbon monoxide(suicide)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 10-3-48Where did injury occur? Cabin John Md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Frank J. Brochart M.D.23. SIGNATURE Sept 1948 exam  
M. D. or otherAddress Washington Md Date signed 10-3-48

## DURATION

Found dead in auto with keys attached to exhaust

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Farb - Dept. of Justice - U.S. State Police - Baltimore  
11/3/48 MO 3701 + P. 101 - (Mr. King to be in)



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10611

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 27 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 27 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County P.G.  
City or town Riverdale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4808 Riverdale Road  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWI

### 3. (a) FULL NAME

LeBEAU, Henry Joseph

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Virginia Anna LeBeau

7. Birth date of deceased (mo., day, yr.) August 5, 1889 6. (c) If alive, give age years

8. AGE: Years 59 Months 2 Days 20 If less than one day hrs. min.

9. Birthplace Canada  
(Town, county, and state)

10. Usual occupation Crane Operator

11. Industry or business Naval Gun Factory

12. Name LeBeau, Adolph dec

13. Birthplace Canada

14. Maiden name Butcher, Victorine dec

15. Birthplace Canada

16. Informant wife: Mrs. Virginia A. LeBeau

Address 4808 Riverdale Road, Riverdale, Md.

17. burial Date thereof 10-28-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington National

Location Suitland, Maryland

18. Funeral director W. A. W. CHAMBERS

Address Riverdale, Maryland

19. 10-25 1948 Mary C. Patterson  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 25 October 19 48 at 12:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 September 19 48 to 25 October 19 48 and that I last saw him alive on 25 October 19 48

Immediate cause of death Peritonitis, Post Operative DURATION 5 days

Due to

Due to

Other conditions Adenocarcinoma, Stomach

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Stomach

Date of op. 10-13-48

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. N. SHERRY, Cdr. MC USN

Address USNH Bethesda, Md. Date signed 10-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





Evidence for correction of  
birth date and age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10612

ALM No. G 117 OCT 13 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 229

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital, Takoma Park

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County...

City or town... Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1601 Grace Church Road  
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Mrs. L. Fern Lebret

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife... John E. Lebret

6. (c) If alive, give age... years

7. Birth date of  
deceased (mo., day, yr.)

January 2, 1885X 1886

8. AGE:

Years

62 63

Montha

8

Days

29

If less than one day

hrs. min.

9. Birthplace

Michigan

(Town, county, and state)

10. Usual occupation... Housewife -- retired

11. Industry or business... Own Home

MOTHER FATHER

12. Name

Parmenus Faunce

13. Birthplace

Ohio

14. Maiden name

Sarah Shaw

15. Birthplace

Ohio

16. Informant... Lucile Jennings

Address

1601 Grace Church Road, S.S., Md.

17. Removal & burial... Oct. 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Sunset Hills Cemetery

Location... Flint, Genesee County, Michigan

18. Funeral director... Waxner E. Pumphrey, Inc.

Address... 8434 Ga. Ave., Silver Spring, Md.

19. Oct 1 - 1948  
(Data rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Oct. 1, 1948 at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-19-48 to Oct 1, 1948

and that I last saw her alive on Oct 1, 1948

Immediate cause of death

Acute Pulmonary Edema  
Acute Congestive Cardiac fail.

DURATION

Terminal

Due to

Hypertension

3 years

Due to

Arteriosclerosis

3 years

Other conditions

Diabetes Mellitus

3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

Robert A. Hare, M.D.  
Address... Takoma Park, Md. Date signed... 10/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1943

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10613

Reg. Dist. No. 215

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 months, 14 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 4 months, 14 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State D.C. County \_\_\_\_\_  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2900 Connecticut Avenue, N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

LINDSAY, Helen Barrick

### 3. (b) Social Security Number

4. Sex female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife \_\_\_\_\_  
7. Birth date of deceased (mo., day, yr.) September 25, 1877 6. (c) If alive, give age \_\_\_\_\_ years  
8. AGE: Years 71 Months 0 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business \_\_\_\_\_  
12. Name BARRICK, Eugene  
13. Birthplace Md.  
14. Maiden name DRURY, Mary Francis  
15. Birthplace Md.

16. Informant sister: Mrs. Belle Scheibla  
Address 2900 Conn. Ave., N.W., Wash., D.C.  
17. burial Date thereof Oct 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Druid Ridge Cemetery  
Location Baltimore, Maryland  
18. Funeral director Mitchell Funeral Home N.E.D.  
Address Baltimore, Md.  
19. 10-13 1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 October 19 48 at 9:30 A. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 May 19 48 to 12 October 19 48  
and that I last saw him/her alive on 12 October 19 48  
Immediate cause of death Carcinoma of the Breast, st. DURATION 4 1/2 yrs  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Arteriosclerosis, Heart Disease  
a) Multiple bone metastases  
(Include pregnancy within 3 months of death)  
Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

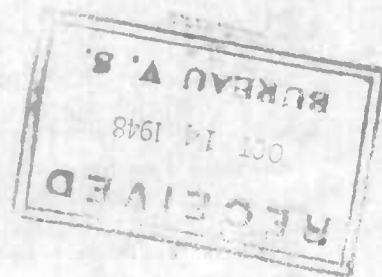
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please noteforce the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
23. SIGNATURE Wm. P. Horton Wm. P. HORTON, Lt. JG MCR USNR  
M. D. or other \_\_\_\_\_  
Address USNH Bethesda, Md. Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10614

Reg. Dist. No. 414

## 1. PLACE OF DEATH:

County Montgomery CountyCity or town Silver Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Mont. CountyCity or town Silver Spring, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 10102 Pierce Dr.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

MARY J. LONGPRE

## 3. (b) Social Security Number

4. Sex

FEMALE

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife ARTHUR. L. LONGPRE7. Birth date of deceased (mo., day, yr.) Oct 21, 18778. AGE: Years Months Days If less than one day  
75 hrs. min.9. Birthplace WASH. DC.  
(Town, county, and state)10. Usual occupation AT. Home.

11. Industry or business

12. Name GEORGE JONES13. Birthplace MD.14. Maiden name MARY KENNEDY15. Birthplace IRELAND.16. Informant MRS. KATHERINE SELFAddress 10102 PIERCE DR. Silver Sp. MD.17. Burial Date thereof OCT 6, 1948  
(Burial, cremation, or removal, White?) (month) (day) (year)Cemetery or crematory MT. OLIVET. CemeteryLocation Wash. DC.18. Funeral director W. Warren TalbotAddress 3619-14 28th N.W.19. Oct. 3 19 48 Joseph W. Schaeffer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 19 48 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 1 19 47 to Oct 3 19 48and that I last saw h. in alive on Oct 2 19 48Immediate cause of death Pneumonia

DURATION

2 dayDue to Cerebral1 mtdDue to HypertensionOther conditions uncertain

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

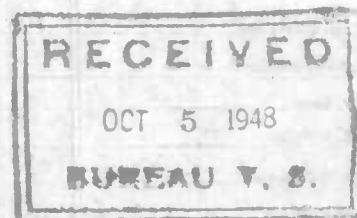
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George L. Ball M.D.Address 7835 Eastern Ave M. D. or otherDate signed Oct 3, 1948



1947  
75  
1872





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **216**

### 1. PLACE OF DEATH:

County **Montgomery**  
City or town **Bethesda**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
**Suburban Hospital**  
How long in hospital or institution? **4 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State **Maryland** County **Montgomery**  
City or town **Rockville**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **Anderson Avenue**  
(If rural, give LOCATION)  
No  
2.(a) If veteran, name war

### 3. (a) FULL NAME

**Mr. Burton Lucas**

### 3. (b) Social Security Number

4. Sex **male** 5. Color or race **white** 6.(a) Single, married, widowed, or divorced **separated**

**male white separated**

6.(b) Name of husband or wife **Annie**

7. Birth date of deceased (mo., day, yr.) **Jan. 25, 1898.** 6.(c) If alive, give age **dec.** years

8. AGE: Years **50** Months **8** Days **11** If less than one day **hrs.** min.

9. Birthplace **Montgomery Co. Md.**  
(Town, county, and state)

10. Usual occupation **Handy man**

11. Industry or business **John Lucas**

12. Name **John Lucas**

13. Birthplace **Va.**

14. Maiden name **Ella Johnson**

15. Birthplace **Md.**

16. Informant **Mr. Phil Reed (friend)**

Address **Rockville, Md.**

17. Burial Date thereof **October 10, 1948**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Darnestown Presbyterian**  
Location **Darnestown, Maryland**

18. Funeral director **Wm. R. Reed**  
Address **Bethesda, Maryland**

19. **10-11** 19 **48** **W E Jones** Registrar  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH **Oct-6, 1948** at **7<sup>10</sup> P.** M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **3:00** 19 **48** to **6:00** 19 **48**  
and that I last saw him alive on **6 Oct 48**

Immediate cause of death **Coronary occlusion**

Other conditions **Post-operative Strangulated Hernia**

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

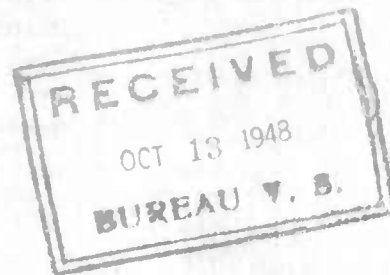
23. SIGNATURE **Chas. H. Jones**

Address **Sub. Hosp. Beth. Md.** Date signed **10-7-48**

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 123

10616

93d

## 1. PLACE OF DEATH:

County MONTGOMERY County  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 36 days  
 Hospital, institution, or street address where death occurred  
Washington Sanatorium & Hospital  
 How long in hospital or institution? 36 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MONTGOMERY  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4 Hickory Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Dolanthe V. Ludwig

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Caucas. 6.(a) Single, married, widowed, or divorced Separated.

6.(b) Name of husband or wife not known

7. Birth date of deceased (mo., day, yr.) August 28, 1884  
 6.(c) If alive, give age not known years

8. AGE: Years 64 Months 1 Days 16 If less than one day  
 ....hrs. ....min.

9. Birthplace Nanticoke Penn.  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name Lyman J. Vandermark13. Birthplace Newport Township, Penn.14. Maiden name Eveline Woomer15. Birthplace Newport Township, Penn.16. Informant chart - relativesAddress Washington Son & Hosp17. Burial Date thereof Oct 16 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Geo Washington Memorial CemeteryLocation Peggy Road, Hyattsville, Md.18. Funeral director J. Arthur WaltersAddress 254 Carroll St. NW, Takoma Park, D.C.19. Oct 14 1948  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1948 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Sept. 6 1948 to Oct. 14 1948  
 and that I last saw her alive on Oct. 13 1948

Immediate cause of death  
Atrophic Pulmonary Emphysema yrs.

Due to Generalized Arteriosclerosis  
Myocarditis

Due to Colitis  
Withtral stricture

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. V. K. Madsen M.D.  
 M. D. or other

Address Takoma Park, Md. Date signed 10-14-48

RECEIVED

OCT 16 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 6 PM 10-11-48Hospital, institution, or street address where death occurred: Suburban Hospital, 8600 Old Georgetown Rd., Bethesda Md.How long in hospital or institution? Since 10-11-48 - 6 PM

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.City or town Glen Echo Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7011 McArthur Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mr Howard M. Lynch

## 3. (b) Social Security Number

None

## 4. Sex

m

## 5. Color or race

wh

## 6. (a) Single, married, widowed, or divorced

s6. (b) Name of husband or wife single5-14-18786. (c) If alive, give age — years

## 7. Birth date of deceased (mo., day, yr.)

## 8. AGE:

76 Years 76 Months 4 Days 28 hrs. — min.9. Birthplace Croftly Maryland  
(Town, county, and state)10. Usual occupation laborer

## 11. Industry or business

12. Name Unknown Marvin B. Lynch13. Birthplace Montgomery Co., Md.14. Maiden name Annie Davis15. Birthplace Montgomery Co., Md.16. Informant Old chart of former adm.

Address

17. Burial Date thereof October 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Potomac Church CemeteryLocation Potomac, Maryland18. Funeral director Wm. Ransom ThompsonAddress Bethesda, Maryland19. 10-14 19 48

(Date rec'd by registrar)

W.E. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12- 19 48 at 12 <sup>15</sup> P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-11-48 19 — to 10-12-48 19 —and that I last saw him alive on 10-12-48 19 —

Immediate cause of death

Arteriosclerosis  
Pulmonary infarction

Due to

Arteriosclerotic Cardio-  
vascular disease

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Boyland, M.D.

M. D. or other

Address Suburban HospitalDate signed 10-12-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incomplete or incorrect information may result in a certificate being rejected. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 18 1948  
BUREAU V. B.

RECEIVED  
OCT 18 1948  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

10618

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Month

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

48

Joseph C. Schaffer

19

48

Joseph C. Schaffer

19

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Joseph C. Schaffer

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Joseph C. Schaffer

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Joseph C. Schaffer

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Joseph C. Schaffer

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Joseph C. Schaffer

## MEDICAL CERTIFICATION

20. DATE OF DEATH

October 28, 1948, at 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22, 1933, to October 28, 1948

and that I last saw him alive on October 27, 1948

Immediate cause of death

DURATION

Auricular fibrillation

Coronary thrombosis

Due to Hypertension

Diabetes mellitus

Due to Cerebrovascular

Other conditions Cholangitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



RECEIVED  
NOV 3 1948  
BUREAU A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Chertea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10619

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months, 6 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 11 months, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md. County...  
 City or town... Silver Spring  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 8003 Eastern Drive  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... WWII

## 3. (a) FULL NAME

McGUIRE, William George

## 3. (b) Social Security Number

4. Sex... male 5. Color or race... W-US 6. (a) Single, married, widowed, or divorced... married  
 6. (b) Name of husband or wife... Anna McGuire  
 7. Birth date of deceased (mo., day, yr.)... December 8, 1900 8. (c) If alive, give age... years  
 8. AGE: Years... 47 Months... 9 Days... 23 It less than one day... hrs. min.

9. Birthplace... Mass. (Town, county, and state)  
 10. Usual occupation... Retired Navy  
 11. Industry or business  
 12. Name... McGuire, John  
 13. Birthplace... N.Y.  
 14. Maiden name... Killilia, Mary L.  
 15. Birthplace... Mass.

16. Informant... Wife: Mrs. Anna McGuire  
 Address... 8003 Eastern Drive, Silver Spring, Md.  
 17. burial Date thereof... 10-5-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Arlington National  
Arlington, Va.  
 Location...  
 18. Funeral director... Reuben Pumphrey J. S. Walton  
 Address... 7557 Wisconsin Avenue, Bethesda, Md.  
 19. 10-1 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... October 1 19 48 at 1:53 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
25 October 19 47 to October 1 19 48  
 and that I last saw him alive on October 1 19 48  
 Immediate cause of death... Cachexia  
 Due to... Carcinomatous  
primary testis  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)  
 Major findings of operations... Find malignant  
testicular tumor Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE... P. L. BATES, Lt. JG MC USN  
 M. D. or other  
 Address... USNH Bethesda, Md. Date signed... 10-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 4 1948  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10620

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months, 18 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 months, 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Mary's  
 City or town St. George Island  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

McKENNY, David Amos

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Lottie McKenny  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 8, 1887

8. AGE: Years 61 Months 5 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Carpentari

11. Industry or business

12. Name McKENNY, Henry dec.

13. Birthplace Va.

14. Maiden name BROWN, Martha dec.

15. Birthplace Va.

16. Informant Wife: Mrs. Lottie McKenny

Address St. George Island, Maryland

17. burial Date thereof 10-15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. George's Island

Location St. Mary's County, Md.

18. Funeral director Chambers Funeral Home

Address 1400 Chapin St., N.W., Wash., D.C.

19. 10-12-48 cc Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1948 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 July 1948 to 12 October 1948 and that I last saw him alive on 12 October 1948

Immediate cause of death Acute Myocardial Failure DURATION Indefinite

Due to Arteriosclerotic Heart Disease Indefinite

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

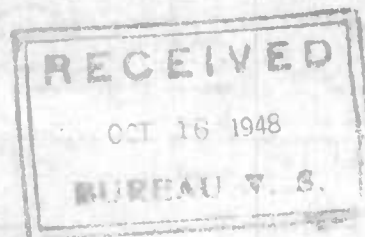
Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. F. BERRY Lt JG MC USN

Address USNH Bethesda, Md. M. D. or other 10-12-48

\_\_\_\_\_ Date signed \_\_\_\_\_



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10621

Reg. Dist. No. 2/3

## 1. PLACE OF DEATH:

County... Montgomery  
City or town... Travilah  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery  
City or town... Travilah  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

ANNE ELIZABETH MERENLESS

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife... James Lothrop

6. (c) If alive, give age... years

7. Birth date of  
deceased (mo., day, yr.)March 21, 1854

8. AGE:

Years

Months

Days

If less than one day

94624

hrs.

min.

9. Birthplace... St. Johns Barracks, Canada  
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

FATHER  
MOTHER12. Name... Francis Richardson13. Birthplace... Scotland14. Maiden name... Fannie Alicia Tunsted15. Birthplace... England16. Informant... Fanny M. SmithAddress... Travilah, Md.17. Cremation Date thereof... 10/18/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Cedar HillLocation... Washington, D. C.18. Funeral director... W. Paulus ThompsonAddress... 7557 Wisconsin Ave. Bethesda, Md.19. 10-16 19 48  
(Date rec'd by registrar)19 48E.P. Thompson

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 15 October 19 48 at 9:37 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 August 19 48 to 15 Oct 19 48and that I last saw him alive on 14 Oct 19 48Immediate cause of death... Congestive Heart Failure

DURATION

2 weeksDue to... Arteriosclerosis30 years

Due to...

Other conditions... Fracture right Hip2 months

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of 8/15/48Where did injury occur? Travilah, Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury... Fell out of bed Injured at work? 11/20/48

23. SIGNATURE

M. D. or other

Address... Rachonville Md Date signed... 15 Oct 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 21 1948

BUREAU Y. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10622

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 7 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 3 months, 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Va. County \_\_\_\_\_  
 City or town Arlington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1203 N. Harrison St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

METZ, Clarence Charles

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Elmira B. Metz  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 28, 1896  
 8. AGE: Year 52 Month 4 Day 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

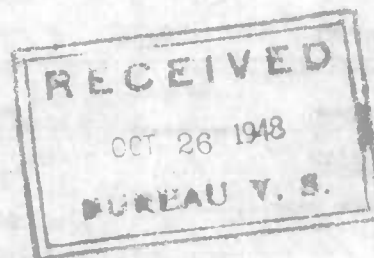
8. Birthplace N.Y.  
 (Town, county, and state)  
 10. Usual occupation Captain of Special Police  
 11. Industry or business Interior Department  
 12. Name METZ, Charles dec.  
 13. Birthplace N.Y.  
 14. Maiden name TWEED, Florence E. dec.  
 15. Birthplace N.Y.

16. Informant wife: Mrs. Elmira B. Metz  
 Address 1203 N. Harrison, Arlington, Va.  
 17. burial Date thereof 10-26-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director First General Home  
 Address 2847 Wilson Blvd. Arlington Va.  
 19. 10-23-48 Mary C. Patterson  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 October 1948 at 2:35 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
16 July 1948 to 23 October 1948  
 and that I last saw him alive on 23 October 1948  
 Immediate cause of death Tuberculosis, military  
 DURATION Indef.  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Peritonitis Indef  
Carcinoma prostate Indef  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE W. N. Miller, Jr. Lt MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 10-23-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County... *Montg Co*  
 City or town... *Gaithersburg Md*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *11-24-48*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *md* County... *montg*  
 City or town... *Gaithersburg*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*Wilpha May Michael*

## 3. (b) Social Security Number

4. Sex

*Female*

5. Color or race

*White*

6. (a) Single, married, widowed, or divorced

*Single*

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *Oct 24* 19*48*, at *11:32 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*09-4-* 19*48* to *08-24-* 19*48*  
 and that I last saw him alive on *08-22-* 19*48*

Immediate cause of death

DURATION

*Coronary occlusion*  
*Due to* *arteriosclerosis*  
*Due to* *hypertrophic degeneration*  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *William C. Miller MD*Address *Gaithersburg Md* Date signed *10/25/48*

## 11. Industry or business

*John E Michael*

12. Name

13. Birthplace *Md*14. Maiden name *Sarah Durrant*15. Birthplace *Md*16. Informant *Records Mathews Home*Address *Gaithersburg Md*17. Burial Date thereof *10/26/48*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Forest Oak Cemetery*Location *Gaithersburg Md*18. Funeral director *D C Jackson*Ad *Gaithersburg Md*19. *Oct 25* 19*48* *Charles G Cook*

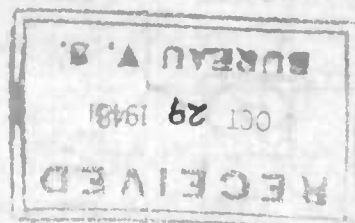
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45:15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10623



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10624  
276

1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: Suburban Hospital  
Stay in hospital or inst. (yrs., or mos., or days) 5 days  
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
City or town Silver Spring Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 9411 Columbia Blvd.  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

George H. Milne

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B (b) Name of husband or wife Ella Milne

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 3, 1887

8. AGE: Years 61 Months 3 Days 22 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
(Town, county, and state)

10. Usual occupation Librarian, Chief Reader

11. Industry or business Library of Congree

FATHER 12. Name Alexander Milne

13. Birthplace Scotland

MOTHER 14. Maiden name Isabella Metcalf

15. Birthplace New York

16. Informant Mrs Ella Milne

Address 9411 Columbia Blvd. Sil. Spg. Md.

17. Burial Date thereof Oct. 28, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lake View Cemetery

Location Cleveland, Ohio

18. Funeral director Wm. E. Humphrey, Inc.

Address 8434 Ga. Ave. Silver Spring, Md.

19. Oct. 28 48 19 St. M. E. Jones

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 19 48, 5:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-17 19 48, to 10-25 19 48, and that I last saw him alive on 10-24 19 48.

Immediate cause of death \_\_\_\_\_ DURATION

Coronary Occlusion 3 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Angina Pectoris 4 yrs.

Myocarditis

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy coronary occlusion

subcoronary infarction

hypertension

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

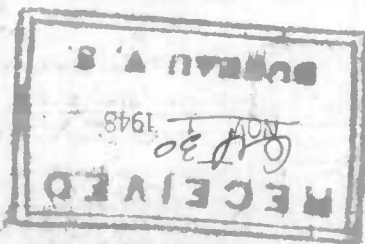
23. SIGNATURE W. E. Humphrey M. D. or other

Address 9401 Georgia Ave Date signed 10/26/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10-13-48-1:30 P.M.Hospital, institution, or street address where death occurred: Suburban Hospital  
8600 Old Georgetown Rd Bethesda Md.How long in hospital or institution? Since 10-13-48-1:30 P.M.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mrs Mary F. Mobley4. Sex F 5. Color or race wh 6. (a) Single, married, widowed, or divorced \_\_\_\_\_B.(b) Name of husband or wife Mr Wallace Mobley

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 4-26-18828. AGE: Years 66 Months 5 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Montgomery Md  
(Town, county, and state)10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

12. Name Albert Ware13. Birthplace Md -14. Maiden name Louise Purvizi15. Birthplace Md.16. Informant Son (Jacob Mobley)Address Gaithersburg Md -17. Burial Date thereof 10/16/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Forest Oak CemeteryLocation Gaithersburg Md18. Funeral director James C. FisherAddress Gaithersburg Md.19. Oct 16 1948 Abide G. Goble  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1948 at 8:50 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 Oct 1948, to 14 Oct 1948and that I last saw her alive on 14 Oct 1948Immediate cause of death Shock, profuse DURATION \_\_\_\_\_Due to Shock of bowelDue to Intestinal Obstruction - due to incarcerated hernia + adhesionsOther conditions Arteriosclerotic cardiac vascular disease + Obesity

(Include pregnancy within 3 months of death)

Major findings of operations Incised hernia + small intestine adhesions Date of op. 13 Oct 48

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Owen That honey M. D. or other \_\_\_\_\_Address Suburban Hosp. Date signed 14 Oct 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



VS A15

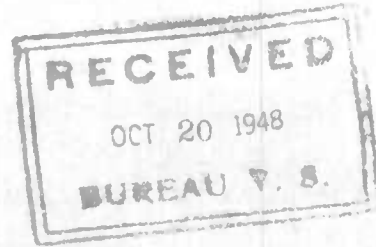
9-45-15M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

### 1. PLACE OF DEATH:

County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 days  
Hospital, institution, or street address where death occurred:  
Suburban Hospital

How long in hospital or institution? 3 1/2 days

### 3. (a) FULL NAME

Mrs. Bernietta A. Moore

4. Sex W 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife William J. Moore

7. Birth date of deceased (mo., day, yr.) 11-13-1875

8. AGE: Years 72 Months 11 Days 9 It less than one day hrs. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name William McAllister

13. Birthplace Baltimore, Md.

14. Maiden name Barbara Young

15. Birthplace Baltimore Md.

16. Informant Mrs. Bluma M. Moore

Address Seafield Va.

17. Burial Date thereof Oct. 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory George Washington Memorial

Location Riggs Road, Md.

18. Funeral director Warner E. Pumphrey, Inc.

Address Silver Spring, Md.

19. 1948 19 48 W.E. Jones  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Prince George

City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6402 Medway Dr. N. Arlington  
(If rural, give LOCATION) Knolly

2. (a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 19 48 at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 48 to October 22 19 48

and that I last saw him alive on October 21 19 48

Immediate cause of death Cerebral hemorrhage

Due to Hypertension, arterial

Due to Hypertension, arterial

Other conditions Hypertensive heart disease

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

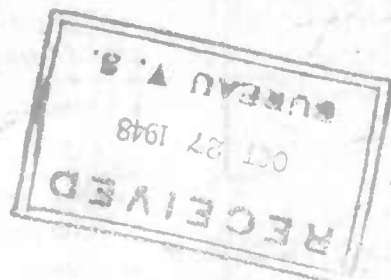
Means of Injury Injured at work?

23. SIGNATURE Arnon H. Traum M.D.

Address 8237 Georgia Ave Silver Spring, Md.

Date signed 10/22-48

7-22-  
1948-70-22  
72-11-9  
1873-11-13



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 212

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Barnesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 69 yrs.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Barnesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Fanny Maude Morningstar

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Algie Morningstar  
 6.(c) If alive, give age 69 years  
 7. Birth date of deceased (mo., day, yr.) Aug. 12 1879  
 8. AGE: Years 69 Months 2 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Barnesville, Montg. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife

## 11. Industry or business

12. Name Allen Orme  
 13. Birthplace Maryland  
 14. Maiden name Harriet G. Smith  
 15. Birthplace Maryland

16. Informant Algie Morningstar  
 Address Barnesville Md.

17. Burial Date thereof 11 2 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy  
 Location Becksville, Md.

18. Funeral director Wm. B. Hilton  
 Address Barnesville, Md.

19. Nov. 1 1948 Mrs. C.C. Hilton  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 October 1948 at 12:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 September 1948 to 31 October 1948  
 and that I last saw him alive on 31 October 1948

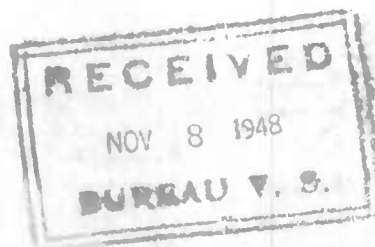
Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_  
Coeur pulmonaire 6 mos  
 Due to Pulmonary fibrosis 1 1/2 yrs.  
 Due to Pulmonary tuberculosis 3 yrs.  
 Other conditions none  
 (Include pregnancy within 3 months of death)

Major findings of operations none Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John S. Fawcett M.D.  
P.O. Bayds, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 51 Oct. 48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10628

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Chevy Chase  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred:

4614 Nottingham Drive.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3112 Rodman St., N. W.

(If rural, give LOCATION)

2.(a) If veteran, name war No

## 3. (a) FULL NAME

Harriet Sophia Murphy

## 3. (b) Social Security Number

No

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John Murphy

7. Birth date of

deceased (mo., day, yr.)

April 4, 18576. (c) If alive, give age Dec. years

8. AGE:

Years

Months

Days

If less than one day

9191617hrs.min.9. Birthplace New York City, New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER

12. Name

Maurice Walsh

13. Birthplace

Ireland

14. Maiden name

Maria Jackson

15. Birthplace

Ireland16. Informant Mr. James L. QuinnAddress 4614 Nottingham Dr., Ch. Ch., Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Oct. 25, 1948

(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Washington, D. C.

18. Funeral director

Address

W.M. Landon Humphrey  
Bethesda, Maryland19. Oct. 25 19 48

(Date rec'd by registrar)

Registrar W.E. Jones

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 19 48 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 18, 1948 to Oct. 22, 1948and that I last saw him alive on Oct. 22, 1948

Immediate cause of death

Coronary occlusion

DURATION

5 days

Other

Generalized arteriosclerosis10 yrs?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Earl G. Bauerfeldt, Jr.  
Bethesda, Md. Date signed 10/23/48

M. D. or other

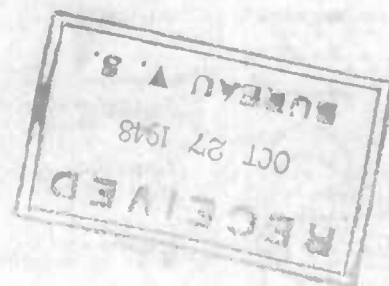
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10629

Reg. Diat. No. 214

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2311 Arthur Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2311 Arthur Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Frank S. Murray

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Rosa Lou Murray

7. Birth date of deceased (mo., day, yr.)

May 10, 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

78425

hrs.

min.

9. Birthplace Fort Valley, Ga.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Anna W. Murray

13. Birthplace

Fort Valley, Ga.

14. Maiden name

Emma Anderson

15. Birthplace

Fort Valley, Ga.

16. Informant

Thomas N. Farrell

Address

2311 Arthur Ave., S.S., Md.17. Transportation & burial of Oct 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Fort Valley Cemetery

Location

Fort Valley Peach Co., Ga.

18. Funeral director

Waxner E. Humphrey, Inc.

Address

Silver Spring, Md.

19.

Oct 6

19

48 Joseph H. Schaffer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1948 at 10:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 5 1940 to Oct 5 1948  
and that I last saw him alive on Oct 5 1948

Immediate cause of death

Acute Cardiac Deletation

DURATION

10 months

Due to

Generalized Arteriosclerosis  
Kidney & Heart3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

W B Wardrop, M.D.

M. D. or other

Address 857 Bonfanti St. Date signed Oct 6, 1948  
Silver Spring

RECEIVED  
OCT 11 1948  
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10630

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 13 days  
Hospital, institution, or street address where death occurred:  
U.S. Naval Hospital  
How long in hospital or institution? 13 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State District Columbia County  
City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1445 Odgen St N.W.  
(If rural, give LOCATION)  
2. (a) If veteran, name war World War I

### 3. (a) FULL NAME

MYERS, Alonzo Roscoe

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Margaret M Myers

7. Birth date of deceased (mo., day, yr.) 28 June 1896 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 52 Months 3 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, District of Columbia  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Dorsey B. Myers deceased

13. Birthplace Virginia

14. Maiden name Evelyn Gooch deceased

15. Birthplace Virginia

16. Informant Wife: Margaret Myers

Address 1445 Odgen St N W Washington D.C.

17. Burial Date thereof 10-12-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Virginia

18. Funeral director W. W. CHAMBERS

Address 1400 CHAPIN ST N.W. WASHINGTON, D.C.

19. 10-8-48 Mary C. Patterson  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 7 October 1948 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 September 1948 to 7 October 1948  
and that I last saw him alive on 7 October 1948

Immediate cause of death  
Melanoma, Malignant  
Generalized

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

L. E. Watters  
L. E. Watters, Jr. LTJG MC USN

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address U.S. Naval Hospital Bethesda, Md. Date signed 10-8-48

PLEASE WRITE PLAINLY, IN INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 12 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2011 Evarts St., N. E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

MYERS, George Ladania, Sr.

## 3. (b) Social Security Number

577 09 3652

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Vera V. Myers  
 6. (c) If alive, give age years  
 7. Birth data of deceased (mo., day, yr.) September 26, 1889  
 8. AGE: Years 59 Months 0 Days 5 If less than one day hrs. min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Potomac Electric Power Co.  
Washington, D. C.  
 11. Industry or business  
 12. Name MYERS, Thomas P. dec  
 13. Birthplace Pa.  
 14. Maiden name SHIRLEY, Ella dec.  
 15. Birthplace Pa.

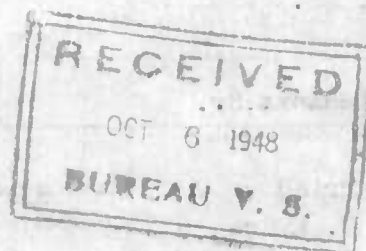
16. Informant wife: Mrs. Vera V. Myers  
 Address 2011 Evarts St., N.E., Wash., D.C.  
 17. burial Date thereof 10-1-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Fort Lincoln  
Bladensburg, Maryland  
 Location  
 18. Funeral director S. H. HINES  
 Address 2901 14th St., N. W., Wash., D.C.  
 19. 10-1 19 48 Mary C. Patterson  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 October 19 48 at 8:50 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 September 1948 to 1 October 1948  
 and that I last saw him alive on 1 October 1948  
 Immediate cause of death arteriosclerotic heart disease & acute left coronary thrombosis  
 Due to arteriosclerosis  
 Due to arteriosclerosis  
 Other conditions obstructive prostatic, tubular atrophy  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Wm. H. Miller, Jr. Lt. MC USN  
 M. D. or other  
 Address USNH Bethesda, Md. Date signed 10-1-48





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Missouri County \_\_\_\_\_  
 City or town Joplin  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Connor Hotel  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Sp. Arm. War ✓

## 3. (a) FULL NAME

NASH, Harry Oscar

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced widowed

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) December 25, 1870 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 77 Months 10 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation unknown

11. Industry or business \_\_\_\_\_

12. Name NASH, ? dec.13. Birthplace ?14. Maiden name SLOANE, ? dec.15. Birthplace Va.16. Informant son: Mr. Harry R. NashAddress Connor Hotel, Joplin, Missouri

17. burial Date thereof 10-29-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director S. H. HINES A.G.L.Address 2901 14th St., N. W., Wash., D.C.

19. 10-28-48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 October 1948 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
15 October 1948, to 27 October 1948  
 and that I last saw him alive on 27 October 1948

Immediate cause of death Arteriosclerosis, Cerebral DURATION 6 Mo.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Wm. F. QUEEN, Cdr. MC USN

Address USNH Bethesda, Md. M. D. or other 10-28-48  
 Date signed \_\_\_\_\_

10632

97

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

10633

### 1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
The Montgomery County General Hospital Inc.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Washington Grove  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

### 3. (b) Social Security Number

Nichols

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) October 25, 1948

8. AGE: Years Months Days If less than one day.  
2 hrs. 13 min.

9. Birthplace Olney, Montgomery Co., Maryland  
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

12. Name Eugene Estes Nichols

13. Birthplace Virginia

14. Maiden name Lillie Mae Gilmore

15. Birthplace Roanoke, Virginia

16. Informant Hospital records

Address \_\_\_\_\_

17. Buried Date thereof Oct 26 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Shelburne Va

Location Soudan Co Va

18. Funeral director Rev W. Barber

Address Gettysville Md

19. Oct 25 19 48 Gertrude B Lawler  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 19 48 at 6:25P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 19 48 to Oct 25 19 48 and that I last saw her alive on October 25 19 48

Immediate cause of death atellusis, Bronch DURATION 2 hrs

Due to respirator

Due to no treatment

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE MRB-1 M. D. other

Address Sandy Spring, Md Date signed 10/25/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10634

838

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda (rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 12 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
How long in hospital or institution? 12 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Texas County \_\_\_\_\_  
City or town Dallas  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6111 Llano Street, c/o Mrs. Wattner  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWII

### 3. (a) FULL NAME

NIEMANN, Charles Henry Jr.

### 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Alene Niemann

7. Birth date of deceased (mo., day, yr.) July 9, 1911 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 37 Months 3 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Texas  
(Town, county, and state)

10. Usual occupation Retired Navy

11. Industry or business \_\_\_\_\_

12. Name NIEMANN, Charles H.

13. Birthplace Tex.

14. Maiden name KAISER, Mary E.

15. Birthplace Tex.

16. Informant wife: Mrs. Alene Niemann

Address 1400 Somerset Place, N.W., Wash., D.C.

17. burial Date thereof \_\_\_\_\_ (month) (day) (year)  
(Burial, cremation, or removal. Which?)

Cemetery or crematory Oaklawn Cemetery

Location Dallas, Tex.

18. Funeral director S. H. HINES

Address 2901 14th St., N.W., Wash., D.C.

19. 10-29 1948 Mary C. Patterson  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 48 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 October 19 48 to 28 October 19 48  
and that I last saw him alive on 28 October 19 48

Immediate cause of death Thrombotic Cerebral  
Sinus DURATION 2 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Aspiration Pneumonia 1 day

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results as above given

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE D. P. Hightower  
D. P. HIGHTOWER, Cdr. MC USN

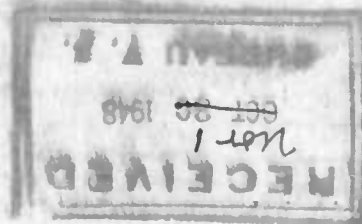
M. D. or other \_\_\_\_\_

Address USNH Bethesda, Md. Date signed 10-29-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10635

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1040 Barnsby Terrace  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

OBENSHAIN, Curry Cooper, Jr.

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth data of deceased (mo., day, yr.) September 21, 1943  
 8. AGE: Years 5 Months 1 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name OBENSHAIN, Curry Cooper  
 13. Birthplace Virginia  
 14. Maiden name BROWN, Elizabeth Ellen  
 15. Birthplace Wash., D.C.

16. Informant father: Curry Cooper Obenshain, S. Sgt.  
 Address 1040 Barnsby Ter., Wash., D.C.  
 17. burial Date thereof 10-28-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
Arlington, Va.  
 Location \_\_\_\_\_  
 18. Funeral director Robert A. Mattingly  
 Address 131 11th St., S.E., Wash., D.C.  
 19. 10-26 1948 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 October 1948 2:10 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 October 1948 to 26 October 1948  
 and that I last saw him alive on 26 October 1948  
 Immediate cause of death Chronic lymphatic  
leukemic leukemia  
 DURATION \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
A. M. Margileth  
 23. SIGNATURE A. M. MARGILETH, Lt JG MC USN  
 M. D. or other \_\_\_\_\_  
 Address USNH Bethesda, Md. Date signed 10-26-48

RECEIVED  
OCT 27 1948  
BUREAU A. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10636

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 days

Hospital, institution, or street address where death occurred:

U.S. Naval HospitalHow long in hospital or institution? 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington CountyCity or town District of Columbia  
(If outside city or town limits, write RURAL and give nearest town)Street No. 630 Webster St. NW  
(If rural, give LOCATION)2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

O'Dea, William Aloysius

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Marie N. O'Dea

B. (c) If alive, give age \_\_\_\_\_ years

## T. Birth date of

deceased (mo., day, yr.)

May 6, 1893

## 8. AGE:

Years 55Months 5Days 1

If less than one day

\_\_\_\_ hr. \_\_\_\_ min.

9. Birthplace Washington, District of Columbia  
(Town, county, and state)10. Usual occupation Industrial Analyst

## 11. Industry or business

12. Name Patrick J. O'Dea deceased

## 13. Birthplace

Ireland14. Maiden name Anne Tobin deceased15. Birthplace Washington, D.C.16. Informant Wife: Marie N. O'DeaAddress 630 Webster St NW, Washington D.C.17. Burial Date thereof 12 October 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington Virginia18. Funeral director Timothy Hanlon T. H.Address 3831 Georgia Ave N W Washington D.C.19. 10-7- 48 Mary C. Patterson  
(Date rec'd by registrar)Mary C. Patterson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 October 19 48 at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

21 September 19 48 to 7 October 19 48and that I last saw him alive on 7 October 19 48

Immediate cause of death

Hypertensive Heart Disease DURATION 3 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE William F. Queen CDR MC USN

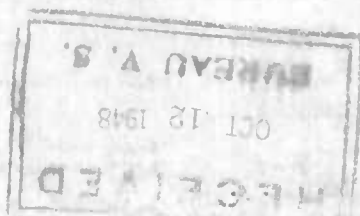
M. D. or other

Address U S Naval Hospital Date signed 10-7-48  
Bethesda, Md

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10637

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 hours  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 25 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State D.C. County Washington  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1924 Varnum St., N.E.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

OEHMANN, Andrew Leroy

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Frances M. Oehmann  
 6. (c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) August 5, 1888  
 8. AGE: Years 60 Months 2 Days 7 If less than one day hrs. min.  
 9. Birthplace Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation Civil Service  
War Dept.  
 11. Industry or business  
 12. Name OEHMANN, Andrew dec  
 13. Birthplace Germany  
 14. Maiden name WALLACHER, Sofia dec  
 15. Birthplace Baltimore, Md.

16. Informant wife: Mrs. Frances M. Oehmann  
 Address 1924 Varnum St., N.E., Wash., D.C.  
 17. burial Date thereof 10-15-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
Arlington National  
 Cemetery or crematory  
Arlington, Va.  
 Location  
 18. Funeral director James T. Ryan R.E.C.  
 Address 317 Pennsylvania Ave., S.E., Wash., D.C.  
 19. 10-12 19-48 Mary C. Patterson  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 October 19 48 at 7:48 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
11 October 19 48 to 12 October 19 48  
 and that I last saw him alive on 12 October 19 48  
 Immediate cause of death  
Thrombosis Coronary Artery  
 DURATION  
33 hrs.  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, pub'c place (where?)  
 Means of injury Injured at work?  
W. F. Queen  
 Wm. F. QUEEN, Cdr. MC USN  
 M. D. or other  
 23. SIGNATURE  
 Address USNH Bethesda, Md. Date signed 10-12-48

RECEIVED  
OCT 14 1948  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 714

## 1. PLACE OF DEATH:

County MontgCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Killed instantly

Hospital, institution, or street address where death occurred:

1800 Block Brisbane St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1830 Brisbane Court  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Barbara Jane Patrick

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife Geo B.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan 23 19468. AGE: Years 2 Months 9 Days 6 It less than one day

..... hrs. .... min.

9. Birthplace Memphis, Tenn  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Geo B. Patrick Jr13. Birthplace N.C.14. Maiden name Muriel Jones15. Birthplace Pa16. Informant Geo B. Patrick JrAddress 1830 Brisbane Ct. Silver Spring Md17. Burial Date thereof 10-29-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Wash. D.C.18. Funeral director W.H. Huntmann Funeral HomeAddress 5732 Georgia Ave N.W. Wash. DC19. Nov. 1 19 48 Joseph M. Schaeff  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19 48 at 3:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death.....

Fracture of skull

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

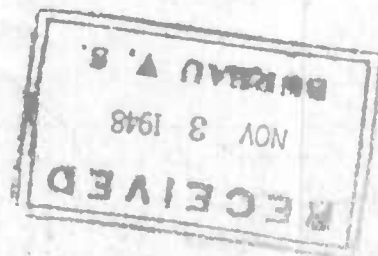
Date of op. ....

Autopsy results.....

PHYSICIAN: Please overline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-29-48Where did injury occur? Silver Spring Montg md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) streetMeans of injury Struck by auto Injured at work? no23. SIGNATURE Frank J. Brochant M.D.  
Dep med exam M. D. or otherAddress Smithsburg Md Date signed 10-29-48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

10639

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 31 days  
 Hospital, institution, or street address where death occurred:  
802 Houston Ave.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County Schenectady  
 City or town Schenectady  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2735 Clyde Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Spanish American ✓

## 3. (a) FULL NAME

Mr. Carl Reinhold Paul

## 3. (b) Social Security Number

074-03-8438-A

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mrs. Susie DeGhe Paul  
 6. (c) If alive, give age 62 years  
 7. Birth date of deceased (mo., day, yr.) Dec. 10, 1877  
 8. AGE: Years 70 Months 10 Days 18 If less than one day hrs. min.

9. Birthplace Angola - Erie - N.Y.  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business  
 12. Name Charles F. Paul  
 13. Birthplace Germany  
 14. Maiden name Freida Miller  
 15. Birthplace ?

16. Informant Mrs. Susie DeGhe Paul  
 Address 2735 Clyde Ave. Schenectady, N.Y.  
 17. Burial Date thereof Nov. 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory  
 Location Schenectady, N.Y.  
 18. Funeral director Arthur J. Jones  
 Address 251 Carroll St., Takoma Park 12, D.C.  
 19. Oct 29 1948 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1948 at 11:45 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1948 to Oct. 28, 1948  
 and that I last saw him alive on Oct. 28, 1948  
 Immediate cause of death Chronic nephritis  
Arteriosclerosis  
 Due to Carcinoma of bladder DURATION 10 days  
 Due to Carcinoma of prostate 2 yrs.  
 Other conditions Metastasis to left shoulder 3 months  
 (Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

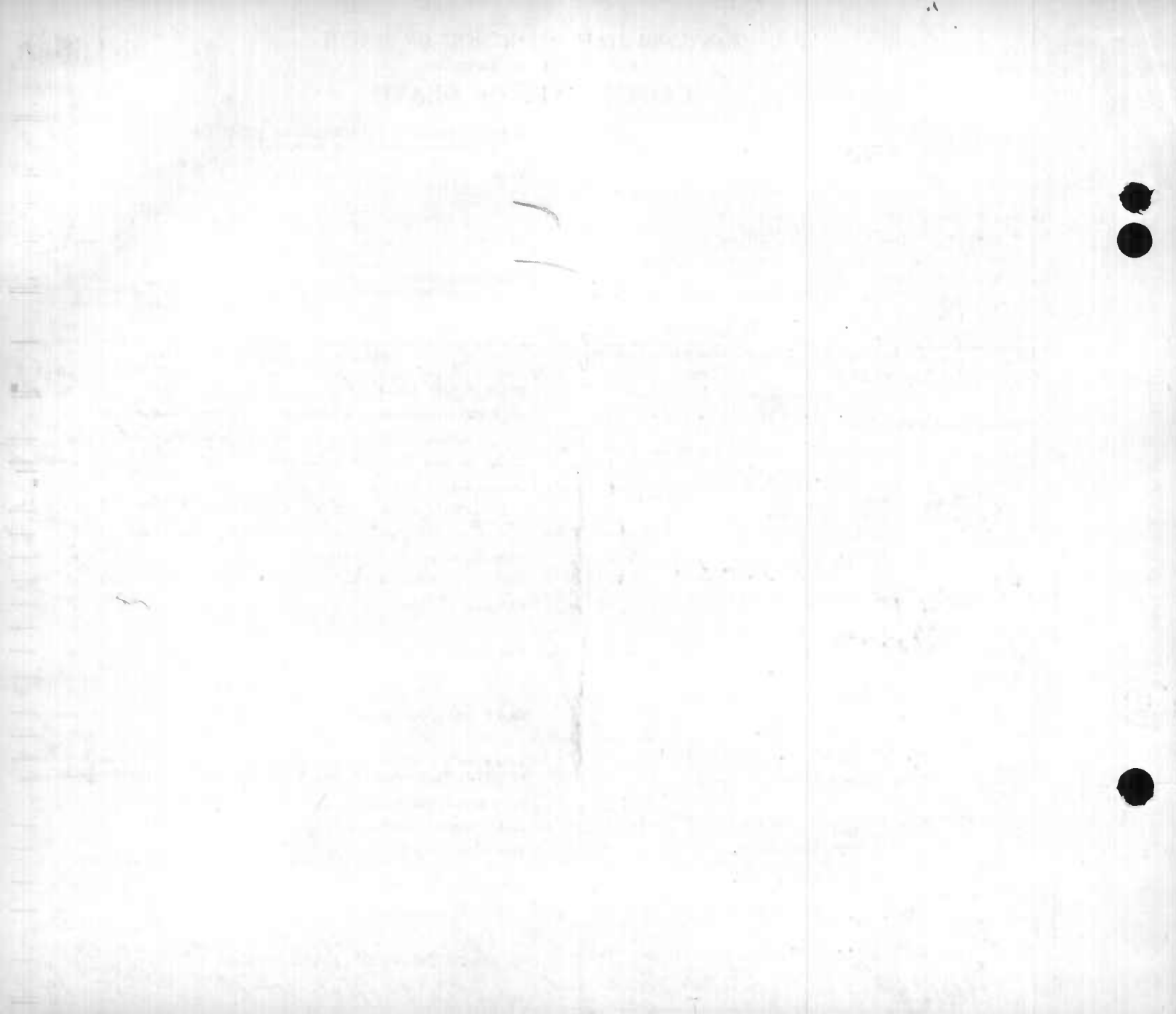
22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE Reed H. Calvert M.D.  
2789 4th Ave. M. D. or other  
Silver Spring, Md. Date signed





23. SIGNATURE 1339-Murphy, N.E. M.D. or other 10/7/4  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

10641

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

Widow

6. (b) Name of husband or wife

Cuthbert Plummer

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

Oct 1st 1893

8. AGE:

Years

Months

Days

If less than one day

55

0

16

hrs.

min.

9. Birthplace

Clarksburg Md -  
(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

"

MOTHER FATHER

12. Name

Doerett, Cecil

13. Birthplace

Md

14. Maiden name

Julia Thompson

15. Birthplace

Md

16. Informant

Levi Price

Address

Prochnitz Md

17

(Burial, cremation, or removal, Which?)

Date thereof

10/24/48  
(month) (day) (year)

Cemetery or crematory

Clarksburg Resurrection

Location

Clarksburg Md

18. Funeral director

J. F. Gathie

Address

Gauthursburg Md

19.

Oct. 19 1948 David G. Cooke  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 17

1948

at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946

to Dec 17

1948

and that I last saw him alive on

Dec 17

1948

Immediate cause of death

Cerebral hemorrhage

DURATION

1.8 hrs

Due to

hypertension

2 yrs

Due to

hypertension

2 yrs

Other conditions

Insulin

2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pubic place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bruchard M.D.

M. D. or other

Address

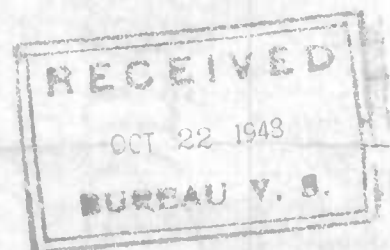
Gauthursburg Md

Date signed 10-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

10642

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Exe. Maryland County   
 City or town Silver Springs  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1001 Marcum Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

POPE, Henry Field

## 3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife   
 6. (c) If alive, give age  years  
 7. Birth date of deceased (mo., day, yr.) March 28, 1889  
 8. AGE: Years 59 Months 6 Days 27 If less than one day  hrs.  min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business People's Drug Store  
 12. Name POPE, Joseph F. dec.   
 13. Birthplace Md.  
 14. Maiden name THOMPSON, Matilda dec.   
 15. Birthplace Md.

16. Informant sister: Mrs. Frances Philips  
 Address 1004 Marcum St., Silver Spring, Md.  
 17. burial Date thereof 10-28-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington, Va.  
 18. Funeral director W. F. Queen Co.  
 Address 1400 - Chapin St. N.W.  
10-23 48  
 (Date rec'd by registrar) Mary C. Patterson Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 October 19 48 at 4:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 October 19 48 to 23 October 19 48  
 and that I last saw him alive on 23 October 19 48  
 Immediate cause of death Thrombosis, Coronary artery DURATION 10 days  
 Due to   
 Due to   
 Other conditions   
 (Include pregnancy within 3 months of death)  
 Major findings of operations  Date of op.   
 Autopsy results confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  Date of   
 Where did injury occur?  (City or town)  (County)  (State)  
 Injured at home, farm, industry, public place (where?)   
 Means of injury  Injured at work?   
 23. SIGNATURE W. F. Queen  
Wm. F. Queen, Cdr. MC MUSE or other  
 Address USNH Bethesda, Md. Date signed 10-23-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10643

94a

216

### 1. PLACE OF DEATH:

County Montgomery  
City or town GREEN ECHO  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 11 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD. County MONTGOMERY  
City or town GREEN ECHO  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7200 BLK - MASS. AVE  
(If rural, give LOCATION)  
2(a) If veteran, name war NONE

### 3. (a) FULL NAME

BENJAMIN FRANKIS POTTIS.

### 3. (b) Social Security Number

NONE

4. Sex M 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED  
6. (b) Name of husband or wife GRACE Katherine BROSNAN  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) JULY 2 - 1895  
8. AGE: Years 73 Months 3 Days 27 hrs. \_\_\_\_\_ min.

9. Birthplace WASHINGTON, D.C.  
(Town, county, and state)

10. Usual occupation TILE SETTER  
11. Industry or business RETIRED.

12. Name UNKNOWN  
13. Birthplace WASH. D.C.  
14. Maiden name UNKNOWN.  
15. Birthplace WASH. D.C.

16. Informant MRS DOROTHY McCauley  
Address 7200 BLK MASS AVE GREENECHO

17. BURIAL Date thereof OCT-29-1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory OAK HILL CEMETERY  
Location WASHINGTON, DC

18. Funeral director W. W. Chambers Co.  
Address 3072 - 11 ST NW, WASH. D.C.

19. 11/2 19 48 J.M.E. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1948 at 12<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 21, 1948 to Oct. 29, 1948  
and that I last saw him alive on October 28, 1948

Immediate cause of death Coronary thrombosis; Coronary sclerosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Generalized atherosclerosis; Hypertrophic arthritis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Elaine W. Murphy MD  
Address 4812 Ellcott St NW Wash DC M. D. or other \_\_\_\_\_

Date signed 10-29-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

10644

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Colesville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Jolliffe Nursing Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State \_\_\_\_\_ County \_\_\_\_\_

City or town Washington, D. C.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 307 F St., N. E.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Henry Price

## 3. (b) Social Security Number

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

male white single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 30, 1855

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
93 5 1

8. Birthplace Norwood, Mass.  
(Town, county, and state)10. Usual occupation Dept. of Interior -- Indian11. Industry or business Affairs12. Name Thomas James Price13. Birthplace Brecon, South Wales, England14. Maiden name Mary Ann Price15. Birthplace Brecon, South Wales, England16. Informant Nelson A. MillerAddress 9604 2nd Ave., Silver Spring, Md.

17. Burial Date thereof Nov. 2, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Wollaston CemeteryLocation Quincy, Norfolk Co., Mass.18. Funeral director Wm. E. Humphrey, Inc.Address 8434 Ga. Ave., Silver Spring, Md.

19. Nov. 1 19 48 Irishman Schaeffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1948 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1948 to Oct. 31, 1948  
 and that I last saw him alive on Oct. 30, 1948

Immediate cause of death Rt. Ventricular Failure  
 DURATION 1 day

Due to Generalized Cardiac Vascular-Renal Dis. Years

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Silver Spring, Md. Date signed 10-31-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

10645

## 1. PLACE OF DEATH:

County Montgomery  
City or town Seamantown Md. Rt. # 1  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

NoneHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Seamantown Md. Rt. # 1  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route no. 1  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3.(a) FULL NAME

GEORGE ROBERT RANDOLPH

## 3.(b) Social Security Number

none

4. Sex

m

5. Color or race

col6.(a) Single, married, widowed or divorced6.(b) Name of husband or wife HANNAH ELIZABETHRandolph6.(c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) February 6, 1872

8. AGE:

Years

Months

Days

If less than one day

76818

hrs.

min.

9. Birthplace Clarkburg, Montgomery Co. Md.  
(Town, County, and state)10. Usual occupation laborer

11. Industry or business

MOTHER

FATHER

12. Name Robert Randolph13. Birthplace Clarkburg Md.14. Maiden name Margaret (last name)15. Birthplace Clarkburg Md.16. Informant Margaret MasonAddress Seamantown Md.17. Burial Date thereof 10/28/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St Rose CemeteryLocation Copper Creek18. Funeral director L. B. FairlessAddress Fairlessburg Md.19. Oct 25 1948 Abdus L Cook  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1948 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March1948 to October 24 1948and that I last saw him alive on October 24 1948

Immediate cause of death

Myocardial pneumonia

DURATION

24 hoursDue to Congestive heart failure2 daysDue to Coronary occlusion7 daysOther conditions Angina pectoris

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results none performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John S. Fawcett M.D.Address P.O. Baydo, Md. Date signed 24 Oct 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

For the undertaker





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? since Oct. 17, 1948  
 Hospital, institution, or street address where death occurred: Suburban Hosp.  
8600 Old Georgetown Rd. - Bethesda Md.  
 How long in hospital or institution? since Oct. 17, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State D.C. County \_\_\_\_\_  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3000 Tilden St. N.W. Wash, D.C.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ No

## 3. (a) FULL NAME

Mr Frederick W. Reeves

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WH

6. (c) If alive, give age \_\_\_\_\_ years

6. (b) Name of husband or wife Alice A. Reeves7. Birth date of deceased (mo., day, yr.) Feb. 4, 18708. AGE: Years Months Days If less than one day  
78 78 8 18 hrs. min.9. Birthplace Washington D.C.  
(Town, county, and state)10. Usual occupation Real Estate Dealer

11. Industry or business

12. Name Geo. W. Reeves13. Birthplace M. York14. Maiden name Emily Wells15. Birthplace Washington D.C.16. Informant Alice A. ReevesAddress 3000 Tilden St., N.W., Wash, D.C.17. Burial Date thereof Oct. 26, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director W. Ruben PumphreyAddress Bethesda, Maryland19. Oct. 25, 1948 Registrar W.E. Jones  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1948 at 12 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1948 to 23 Oct 1948and that I last saw him alive on 23 Oct '48 1948Immediate cause of death Pulmonary thrombosis DURATION  
Pulmonary Edema, EarlyDue to Condition found at autopsy(1) Generalized atherosclerosisDue to Ess. Corneal sclerosis & Central(2) Cerebral hemorrhage, venous & arterialOther conditions (3) Pulmonary thrombosis  
(4) Cerebral hypoxia  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart H. H. M.D. M.D. or otherAddress 3921 Ingomar St. S.W. Date signed 10-23-48  
with DC

10646

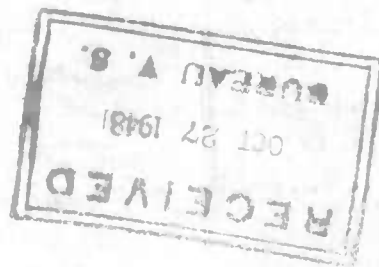
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MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

10648

720

### 1. PLACE OF DEATH:

County Montg.  
City or town Exempt from Damascus to Rockville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montg.  
City or town Damascus  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Barbara Jean Reid

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

### 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb 8 1948 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months 8 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Damascus, Montg. Md.  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Mr Eugene Reid

13. Birthplace Boysen, Md

14. Maiden name Nellie Mary Beale

15. Birthplace Yanther, Md

16. Informant Mrs Wm Reid

Address Damascus, Md

17. Burial Date thereof Oct 23 1988  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Methodist Bero

Location Damascus, Md

18. Funeral director J. B. Beall, Inc.

Address Damascus, Md

19. Oct 22 88 Della K Burdett  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1988 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept med exam to cause 19\_\_\_\_ and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

DURATION

Purpura haemorrhagica 12 hrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Antopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Frank J. Broschart M.D.

Sp. med. exam. M. D. or other \_\_\_\_\_

Address Chesapeake, Md Date signed 10.22.88

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED  
OCT 26 1948  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Killed instantly

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Layhill  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. Silver Spring R.F.D.#1  
(If rural, give LOCATION)2.(a) If veteran, name war World War II-Army

## 3. (a) FULL NAME

Robert Clarence Rhea

## 3. (b) Social Security Number

414-12-6527

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1948, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med exam 1948 to 1948  
and that I last saw him alive on 1948

Immediate cause of death

DURATION

Fracture of 3rd cervical vertebra  
Due to accident

Due to

Other conditions

Crowned chest

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-21-48Where did injury occur? Bethesda md  
(City or town) (County) (State)Injured at home, farm, industry, pub'c place (where?) public placeMeans of injury Crushed by bulldozer Injured at work? yesFrank J. Broschart M.D.  
Dep. med exam23. SIGNATURE W.E. Jones M. D. or otherAddress Switzersburg md Date signed 10-21-48

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bonnie RheaJune 13, 1915 6. (c) If alive, give age 27 years

## 7. Birth date of

deceased (mo., day, yr.) June 13, 1915

## 8. AGE:

Years 33 Months 33 Days 4 If less than one day  
hrs. 8 min.9. Birthplace Sneedville, Tenn.

(Town, county, and state)

10. Usual occupation Bulldozer Operator11. Industry or business Francis O. Day Company

## MOTHER

## FATHER

12. Name Sherman L. Rhea13. Birthplace Tenn.14. Maiden name Catherine Kampa15. Birthplace Wisconsin16. Informant Bonnie RheaAddress R.F.D.#1, Silver Spring, Md.

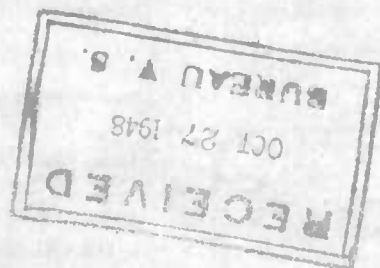
## 17. Burial

(Burial, cremation, or removal. Which?) Date thereof Oct. 26, 1948  
(month) (day) (year)Cemetery or crematory Sunshine Memorial Family PlotLocation Maryland, Sunshine

## 18. Funeral director

Address Wm. Raulsen Pumpfun  
Bethesda, Maryland19. Oct. 25, 1948  
(Date rec'd by registrar)

Registrar



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10649 216

### 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 days  
Hospital, institution, or street address where death occurred:  
Suburban 1100  
How long in hospital or institution? 3 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Montgomery  
City or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5206 Glenwood Rd.  
(If rural, give LOCATION)  
2. (a) If veteran, name war First World War

### 3. (a) FULL NAME

Mr. Edward F. Rowse

### 3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Martha Stuart Rowse

7. Birth date of deceased (mo., day, yr.) July 26 1896

8. AGE: Years 52 Months 3 Days 0 If less than one day - hrs. - min.

9. Birthplace St. Louis Missouri  
(Town, county, and state)

10. Usual occupation Cheerist

11. Industry or business National Cheerist (Retired)

12. Name Edward F. Rowse

13. Birthplace Boston Mass.

14. Maiden name Katharine Louise Green

15. Birthplace Braintree New Hampshire

16. Informant Mrs. Edward F. Rowse

Address 5206 Glenwood Rd. Bethesda

17. Cremation Date thereof October 25, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Washington, D.C.

18. Funeral director W. K. Rube Humphrey

Address 7557 Wis. Ave. Bethesda, MD.

19. 5-25 48 W. J. Jones  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1948, at 6:05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1948, to Oct 25 1948

and that I last saw him alive on Oct 25 1948

Immediate cause of death Cerebral apoplexy

Due to Alzheimer's dis., cerebral arterio-sclerosis & encephalopathy

Due to hypertensive arterial disease

Other conditions Terminal renal decompensation

Major findings of operations None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

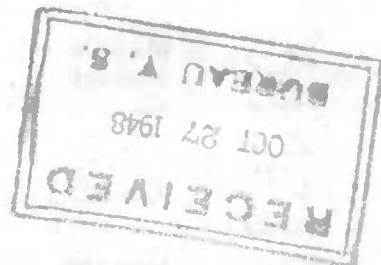
23. SIGNATURE Edward F. Rowse M. D. or other

Address 1726 Eye St. N. W. Date signed 10/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County Montg Co.  
 City or town Gaithersburg, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Montgomery  
 City or town Gaithersburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Seabury Methodist Home  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertie Olivia Selby  
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced  
 6.(b) Name of husband or wife Harry W. Selby  
 7. Birth date of deceased (mo., day, yr.) Sept 13 - 1872  
 6.(c) If alive, give age years

## 3. (b) Social Security Number

8. AGE: Years 76 Months 0 Days 21 If less than one day hrs. min.

9. Birthplace Howard Co., Md.  
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Thomas S. Cross  
 13. Birthplace Md.

14. Maiden name Emma Stansfield

15. Birthplace Md.

16. Informant Methodist Home Records  
 Address Gaithersburg, Md.

17. Burial Date thereof 10/6/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount View Cemetery

Location near Coopersville, Md.

18. Funeral director E. J. Garton

Address Gaithersburg, Md.

19. Oct. 4 19 48 Abner S. Cooke  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH OCT - 4 - 1948 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 6 - 1948 to OCT - 4 - 1948  
 and that I last saw him alive on OCT - 2 - 1948

Immediate cause of death  
Cystic Refractor  
Carcinoma of bowel  
 DURATION 12 years  
3 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D.  
 M. D. or other

Address Gaithersburg, Md. Date signed 10/4/48

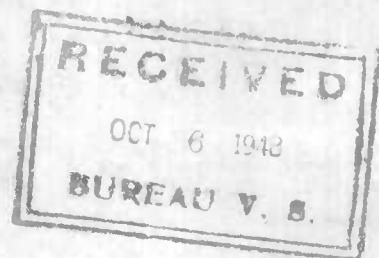
10650

462

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

OCT 6 1948

BUREAU V. S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

10651

## 1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1316 Fenwick Lane

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1316 Fenwick Lane

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

JOHN FRANKLIN SHORB

## 3. (b) Social Security Number

214-03-9678

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

malewhitemarried6. (b) Name of husband or wife Hattie K. Shorb6. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) June 2, 18788. AGE: Years Months Days If less than one day  
70 4 29 hrs. min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Employed at Naval Ordnance Lab.

11. Industry or business

12. Name John F. Shorb13. Birthplace Virginia14. Maiden name Maria Louise Bitzer15. Birthplace Virginia16. Informant Mrs. Hattie K. ShorbAddress 1316 Fenwick Lane, Silver Spring, Md.17. Burial Date thereof Nov. 2, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory George Washington MemorialLocation Riggs Rd., Md.18. Funeral director Wm. E. Humphrey, Inc.Address 8434 Georgia Ave., Silver Spring, Md.19. Nov. 1 1948 Joseph W. Schaefer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1948 at 11:26 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 31, 1948 to Oct 31, 1948  
and that I last saw him alive on Oct 31, 1948

Immediate cause of death

DURATION

Cerebral thrombosis3 1/2 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 4901 Marsh Lane NW Date signed 10-31-48  
Wash D.C.

RECEIVED  
NOV 3 1948  
BUREAU A. S.

Evidence for change of  
mother's maiden name:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10652

FILM NO. G 118 NOV 30 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Since 8:25 PM Oct. 6, '48  
Hospital, institution, or street address where death occurred: Suburban Hospital  
8600 Old Georgetown Rd. Bethesda Md.  
How long in hospital or institution? Since birth Oct. 6, '48 1 PM

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Montgomery  
City or town Gaithersburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
3. (a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

James Harold Slye  
Baby boy Slye

3. (b) Social Security Number

4. Sex

m

5. Color or race

wh.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.) October 6, 1948 - 8:02 PM

8. AGE:

Years

Months

Days

If less than one day

-

-

-

2

- hrs. - min.

9. Birthplace

Suburban Hospital - Bethesda Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1948, at 7:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 PM Oct. 6, 1948 to A.M. Oct. 8, 1948

and that I last saw him alive on 19

Immediate cause of death

Hemorrhagic - Broncho  
Pneumonia - Primary Cause

Due to

Atelectasis contributing  
Factor

Due to

Dr. Murphy  
by A. Thie

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. B. Murphy Md.  
Rockville Md.  
Address \_\_\_\_\_ Date signed 8 Oct 48

M. D. or other



McLain's name  
de lais  
Jas B.C. 10-48  
Ment.

9-10-48 - 4:45 P.M.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

10653

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 41 days

Hospital, institution, or street address where death occurred:

Suburban 71st St. 8600 Old GeorgetownHow long in hospital or institution? 41 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5201 Rosecroft St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Harley Smith

## 3. (b) Social Security Number

272-01-4741

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edith E Smith

7. Birth date of

deceased (mo., day, yr.) Dec. 10, 18746. (c) If alive, give age 70 years

8. AGE:

Years

Months

Days

If less than one day

731011hrs.min.

9. Birthplace

Cleveland Ohio  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

Garson G. Smith

13. Birthplace

David N. Y.

14. Maiden name

Clara G. Woven

15. Birthplace

Washington Ohio

16. Informant

Mrs. Geo. E. Melanen

Address

5706 York Pa. Bethesda

17. Burial

Oct. 23, 1948

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Cedar Hill Cemetery

Location

Washington, D.C.

18. Funeral director

Wm. R. R. Humphrey

Address

7537 Wis. Ave. Bethesda, Md.

19. 1025 - 48

(Date rec'd by registrar)

WE. Jones

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-48 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1948 to Oct 20, 1948and that I last saw him alive on Oct 20, 1948Immediate cause of death Coronary heart disease

DURATION

Due to hypertension, generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Joseph P. KennickAddress 7942 Wisconsin Ave, BethesdaDate signed 10/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

10654

## 1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Came here as a nurse Aug 12 48Hospital, institution, or street address where death occurred: Suburban Hosp. 8600 Old Georgetown Rd., Bethesda Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda  
(If outside city or town limits, write RURAL and give nearest town)Street No. 8600 Old Georgetown Rd  
(If rural, give LOCATION)2. (a) If veteran, name war None

## 3. (a) FULL NAME

Ruby Christine B. Smith

## 3. (b) Social Security Number

267-01-8072

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Eleazar Smith6. (c) If alive, give age 47 years

7. Birth date of

deceased (mo., day, yr.)

May 12, 1909

8. AGE:

Years

Months

Days

If less than one day

38138426- hrs.- min.

9. Birthplace

Oshka, Mississippi  
(Town, county, and state)

10. Usual occupation

nurse

11. Industry or business

Suburban Hospital

MOTHER FATHER

12. Name

Henry Pugh

13. Birthplace

Denmark

14. Maiden name

Unknown Blanch Burch

15. Birthplace

Miss.

16. Informant

Mrs. Joyce Jordan (daughter)

Address

Ft. Myers, Florida17. Burial - Transit

(Burial, cremation, or removal. Which?)

Date thereof October 10, 1948  
(month) (day) (year)

Cemetery or crematory

Ft. Myers

Location

Ft. Myers, Lee Co., Florida

18. Funeral director

Wm. Ransom Rungberg

Address

Bethesda, Maryland

19.

(Date rec'd by registrar)

19.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 48 at 4:38 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Self med exam 19 48 to 19  
and that I last saw him alive on Case 19 48

Immediate cause of death

Coronary disease

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Bronhart M.D.  
Self med exam

M. D. or other

Address

Washington, D.C.Date signed 10-8-48



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town GLen BCHO HGTS.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Oct 23, 1948Hospital, institution, or street address where death occurred:  
5415 Mohican Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County FranklinCity or town Columbus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1339 E. Broad St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FLORENCE K.

## 3. (b) Social Security Number

SNIVELY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Harry Hamilton (deceased)7. Birth date of deceased (mo., day, yr.) Sept 9, 1872

8. AGE: Years Months Days If less than one day

76 1 16 hrs. min.9. Birthplace Ohio  
(Town, county, and state)10. Usual occupation court reporter - (retired)

11. Industry or business

12. Name George W. Knowlton13. Birthplace Ohio14. Maiden name Martha Miranda Barrell15. Birthplace Ohio16. Informant Margaret Snively TuohyAddress 5415 Mohican Rd.17. REMOVAL Date thereof Oct 28, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Greenlaw CemeteryLocation Columbus Ohio18. Funeral director Joseph Hawley's Sons, Inc.Address 1756 Pa. Ave. N.W. Wash. 6, D.C.19. 10-28 YF W.E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948 at 7:00 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 27 1948and that I last saw him sc alive on Oct 27 1948

Immediate cause of death

Cerebral EmbolismMyocardial infarctionDue to Arteriosclerotic heart

disease with auricular

fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles Liden Jones MD  
M.D. or otherAddress 1629 Columbia Rd. Date signed 10-27-48

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

County MONTGOMERYCity or town GLen BCHO HGTS.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Oct 23, 1948Hospital, institution, or street address where death occurred:  
5415 Mohican Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County FranklinCity or town Columbus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1339 E. Broad St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

FLORENCE K.

## 3. (b) Social Security Number

SNIVELY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Harry Hamilton (deceased)7. Birth date of deceased (mo., day, yr.) Sept 9, 1872

8. AGE: Years Months Days If less than one day

76 1 16 hrs. min.9. Birthplace Ohio  
(Town, county, and state)10. Usual occupation court reporter - (retired)

11. Industry or business

12. Name George W. Knowlton13. Birthplace Ohio14. Maiden name Martha Miranda Barrell15. Birthplace Ohio16. Informant Margaret Snively TuohyAddress 5415 Mohican Rd.17. REMOVAL Date thereof Oct 28, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Greenlaw CemeteryLocation Columbus Ohio18. Funeral director Joseph Hawley's Sons, Inc.Address 1756 Pa. Ave. N.W. Wash. 6, D.C.19. 10-28 YF W.E. Jones  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1948 at 7:00 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 23 1948 to Oct 27 1948and that I last saw him sc alive on Oct 27 1948

Immediate cause of death

Cerebral EmbolismMyocardial infarctionDue to Arteriosclerotic heart

disease with auricular

fibrillation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles Liden Jones MD  
M.D. or otherAddress 1629 Columbia Rd. Date signed 10-27-48

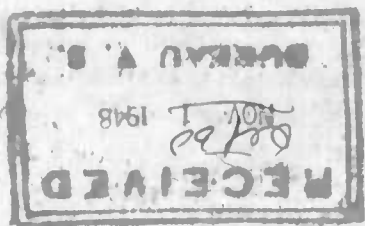
MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SNIVELY



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 10656 223-

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Takoma Park, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 days 14 hrs 25 min  
 Hospital, institution, or street address where death occurred:  
Washington Sanitarium & Hospital  
 How long in hospital or institution? 16 days 14 hrs 25 min

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Virginia County \_\_\_\_\_  
 City or town Fredericksburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1715 Charles St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sollenberger, Mrs. Ida Jane

## 3. (b) Social Security Number

4. Sex Fe. 5. Color or race Cauc. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband Sollenberger, Mr. Russell R.7. Birth date of deceased (mo., day, yr.) October 28, 1887 6. (c) If alive, give age 59 years8. AGE: Years 60 Months 11 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Cumberland Co. Va.  
(Town, county, and state)10. Usual occupation Retired school teacher

## 11. Industry or business

12. Name Adams, Thomas H.13. Birthplace New German town Pa14. Maiden name Elder, Elizabeth M.15. Birthplace Dry Run, Pa16. Informant Pathetic's recordAddress Washington San + Hosp.17. (Burial, cremation, or removal, Which?) Removal Date thereof 10/25/48  
(month) (day) (year)Cemetery or crematory Joy Hill CemeteryLocation Alexandria, Va.18. Funeral director W W Demaine & SonAddress Alexandria, Va.19. Oct-25-1948  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25-1948 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 8-1948 to Oct 25-1948 and that I last saw her alive on Oct 24-1948Immediate cause of death Pelvic abscess DURATION TerminalDue to Carcinoma of Ovary 2 years

Due to \_\_\_\_\_

Other conditions Hydrocephalus Rt. Kidney Terminal

(Include pregnancy within 3 months of death)

Major findings of operations C. R. Ovary Date of op. 7 years agoAutopsy results Conform above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert A. Arendt  
M. D. or other \_\_\_\_\_Address Takoma Park, Md Date signed 10/25/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 hrs 12 minutes  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital  
 How long in hospital or institution? 5 hrs 12 minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District Columbia County .....  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3644 Warder St N W Washington DC  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I ✓

## 3. (a) FULL NAME

SPOONER, Lawrence Eugene

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced  
 6. (b) Name of husband or wife .....  
 6. (c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) January 9, 1901  
 8. AGE: Years 47 Months 8 Days 28 It less than one day ..... hrs. .... min.

9. Birthplace North Carolina  
 (Town, county, and state)  
 10. Usual occupation Taxi-driver  
 11. Industry or business .....  
 12. Name William J Spooner  
 13. Birthplace North Carolina deceased  
 14. Maiden name Rebecca Rhea  
 15. Birthplace North Carolina deceased

16. Informant Sister: Mrs Annie Ray Cook  
 Address 3644 Warder St N W Washington D C  
 17. Burial Date thereof 10-11-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
 Location Arlington Virginia  
 18. Funeral director W. W. Chambers  
 Address 517 11th St S E Washington D. C.  
 19. 10-7- 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 October 1948 at 11:12 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6 October 1948 to 7 October 1948  
 and that I last saw him alive on 7 October 1948

Immediate cause of death Myocarditis, Chronic DURATION 2 yrs

Due to .....  
 Due to .....  
 Other conditions .....  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....

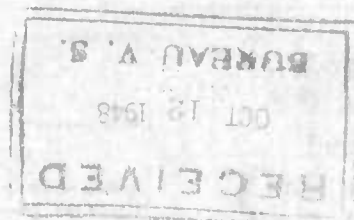
Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....  
 23. SIGNATURE W. F. Queen W. F. Queen CDR MC USN M. D. or other  
U.S. Naval Hospital  
 Address Bethesda, Md. Date signed 10-7-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93e

10658

213

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 316 Grandin Ave.  
 (If rural, give LOCATION)  
 2. (a) Is veteran, name war. No

## 3. (a) FULL NAME

MARY ELLEN TAYLOR

## 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>James Oliver Taylor</u>			
7. Birth date of deceased (mo., day, yr.) <u>April 16, 1864</u>			
6. (c) If alive, give age <u>Deceased</u> years			
8. AGE: Years <u>84</u>	Months <u>84</u>	Days <u>5</u>	It less than one day <u>23</u> hrs. <u>      </u> min.
9. Birthplace <u>Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>			
11. Industry or business <u>Own Home</u>			
12. Name <u>Wm. T. Higgins</u>			
13. Birthplace <u>Maryland</u>			
14. Maiden name <u>Unknown</u>			
15. Birthplace <u>Unknown</u>			
16. Informant <u>Mrs Bertha Creamer</u> Address <u>316 Grandin Ave. Rockville, Md.</u>			
17. <u>Burial</u> Date thereof <u>October 11, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Potomac Church Cemetery</u> Location <u>Potomac, Maryland</u>			
18. Funeral director <u>W. R. Ralston</u> Address <u>7557 Wis. Ave. Bethesda, Maryland</u>			
19. <u>10-11</u> 19 <u>48</u> (Date rec'd by registrar) <u>E. R. Thompson</u> Registrar			

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1948 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19       to Oct 8 1948 and that I last saw him alive on Oct 7 1948

Immediate cause of death Myocardial failure with  
decompensation. DURATION 1 year.

Due to       

Due to       

Other conditions None.

(Include pregnancy within 3 months of death)

Major findings of operations        Date of op.       

Autopsy results       

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide        Date of         
 Where did injury occur?        (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)         
 Means of injury        Injured at work?       

23. SIGNATURE W. R. Ralston, M.D. M. D. or other  
Rockville, Md. Date signed 10/8/48

RECEIVED  
OCT 14 1948  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Spring Lake Park-Rockville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life R.F.D.# 5  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Montgomery  
 City or town Spring Lake Park-Rockville-R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town) #5  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... No

## 3. (a) FULL NAME

Testerman, Steven V.

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) May 15, 1943 6.(c) If alive, give age..... years  
 8. AGE: Years 5 Months 5 Days 27 If less than one day  
5 hrs. 5 min.

9. Birthplace Spring Lake Park, Montgomery, Md.  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Paul E.L. Testerman  
 13. Birthplace N. Carolina

MOTHER 14. Maiden name Blanche Springer  
 15. Birthplace Emmitsburg, Maryland

16. Informant Mrs Blanche Testerman  
 Address Rockville R.F.D.#.5

17. Burial Date thereof October 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sterling Virginia  
 Location Sterling, Virginia

18. Funeral director Wm. Ransom Rumpson  
 Address 7557 Wis. Ave. Bethesda, Maryland

19. 10/13 19 48  
 (Date rec'd by registrar) Registrar E. R. Simpson

## MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 48 19..... at 4:48 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 47 to Oct 12, 48  
 and that I last saw him alive on Oct 10/48 19.....

Immediate cause of death Carcinoma Kidney Rt DURATION ryn.  
 Due to.....  
 Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

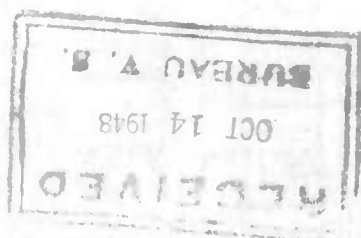
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Samuel Allen M. D. or otherAddress Kerrigan, Md Date signed 10/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

10660

159

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 days  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County \_\_\_\_\_  
 City or town Arlington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2712 Lee Blvd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_ ✓

## 3.(a) FULL NAME

THOMPSON, Pamela Frances

## 3.(b) Social Security Number

4. Sex female 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single  
 6.(b) Name of husband or wife \_\_\_\_\_  
 7. Birth date of deceased (mo., day, yr.) October 13, 1948 8.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Year \_\_\_\_\_ Month \_\_\_\_\_ Day 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bethesda, Md. (rural)  
 (Town, county, and state)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_  
 12. Name THOMPSON, Harry L.  
 13. Birthplace Pa.  
 14. Maiden name LONG, Frances Lucile  
 15. Birthplace Md.

16. Informant father: Cdr. Harry L. Thompson, USN  
 Address 2712 Lee Blvd., Arlington, Va.  
 17. burial Date thereof 10-20-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington National  
Arlington, Va.  
 Location \_\_\_\_\_  
 18. Funeral director W. W. CHAMBERS  
 Address Georgetown, D. C.  
 19. 10-19 19 48 Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 48 at 10:53P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
13 October 19 48 to 18 October 19 48  
 and that I last saw him alive on 18 October 19 48  
 Immediate cause of death Prematurity

## DURATION

5 days

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please endorse the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE J. T. FOWLER, Jr. J. T. FOWLER, Jr. Cdr. MC USN  
 Address USNH Bethesda Md. 10-19-48  
 Date signed \_\_\_\_\_



RECEIVED  
OCT 22 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

10661213

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

### 1. PLACE OF DEATH:

County MONTGOMERY  
City or town ROCKVILLE  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: CHESTNUT LODGE SANITARIUM  
Stay in hospital or inst. (yrs., or mos., or days) 6 days  
Stay in this community (yrs., or mos., or days) 6 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County ST. MARY'S  
City or town LEONARDTOWN Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. \_\_\_\_\_ (If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_

### 3. (a) FULL NAME

JANE CAMPBELL THRIFT

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife EDWIN PORTER THRIFT  
6. (c) If alive, give age deceased

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1876

8. AGE: Years 72 Months 1 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Oldham, Va.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

16. Informant BOH - MAURICE THRIFT

Address Leonardtown, Md

17. Removal Date thereof Oct 27, '48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ebenezer Cemetery

Location Oldham, Va.

18. Funeral director W C Mattingly Sons

Address Leonardtown, Maryland

19. 10/27 48 Councilis  
(Date rec'd by registrar) Registrar

E. P. Thompson

### MEDICAL CERTIFICATION

2D. DATE OF DEATH 27 October 1948, at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 Oct 1948 to 27 Oct 1948, and that I last saw her alive on 26 Oct 1948.

Immediate cause of death Coronary Thrombosis DURATION 3 mos

Due to Arteriosclerotic Heart Disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

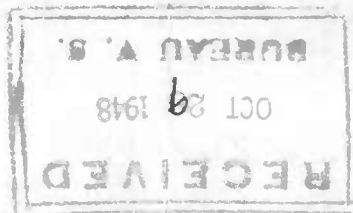
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Marvin L Adland MD M. D. or other

Address Chestnut Lodge Date signed 27 Oct 48  
Rockville

### PHYSICIAN

Please underline the cause to which death should be charged statistically.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

## 1. PLACE OF DEATH:

County Montgomery Co.  
 City or town 45 Poplar Ave., Takoma Pk., Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Aug. 27, 1948

Hospital, institution, or street address where death occurred:  
Spring Villa

How long in hospital or institution? 1 1/2 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County Washington, D.C.City or town Washington, D.C.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1446 Spring Rd., N.W.  
 (If rural, give LOCATION)

2(a) If veteran, name war ✓

## 3. (a) FULL NAME

Nim Trapp

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Sussie Chitwood6. (c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) Oct. 1, 1865

8. AGE: Years 83 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Oskaloosa, Jefferson Co., Md.  
 (Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

12. Name W. D. Trapp13. Birthplace Missouri14. Maiden name Ruth Grimes15. Birthplace Ohio16. Informant Charles C. HayesAddress 1446 Spring Rd., N.W.

17. Burial Burial Date thereof Oct. 9, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln CemeteryLocation 3201 Bladensburg Rd., Colmar Manor, Md.18. Funeral director Wm. J. NalleyAddress 3200 R.I. Ave., Mt. Rainier, Md.

19. Oct 9 48 Trapp Trapp  
 (Date rec'd by registrar) (year) (month) (day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10. 6 19 48 at 6:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 48 to 10 6 19 48and that I last saw him alive on 10. 6 19 48Immediate cause of death arterio sclerosis

DURATION

Due to

Due to

Other conditions Sanity

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. P. Rom M. D. or otherAddress 300 - Hamlet St. N.W. Date signed 10.6.48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

## 1. PLACE OF DEATH:

County... Montgomery  
 City or town... Bethesda (rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 hrs., 50 min.  
 Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Md.  
 How long in hospital or institution? 2 hrs., 50 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Va. County...  
 City or town... Falls Church  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. RFD #2  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war... WWI ✓

## 3. (a) FULL NAME

TURNER, Hugh Ashby

## 3. (b) Social Security Number

4. Sex... male  
 5. Color or race... W-US  
 6. (a) Single, married, widowed, or divorced... married  
 6. (b) Name of husband or wife... Minerva S. Turner  
 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) August 8, 1895  
 8. AGE: Years... 53 Months... 2 Days... 19 If less than one day... hrs. min.

9. Birthplace... Virginia  
 (Town, county, and state)  
 10. Usual occupation... Policeman  
 11. Industry or business  
 12. Name... TURNER, Benjamin A. dec.  
 13. Birthplace... Va.  
 14. Maiden name... CARPENTER, Novella dec.  
 15. Birthplace... Va.

16. Informant... wife: Mrs. Minerva S. Turner  
 Address... Falls Church, Va., RFD #2  
 17. burial Date thereof... 11-1-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory... Arlington National  
Arlington, Va.  
 Location...  
 18. Funeral director... W. W. CHAMBERS F.C.  
 Address... Georgetown, D.C.

19. 10-28- 19 48 Mrs. Mary C. Patterson  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 27 October 19 48 at 2:50 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
27 October 19 48 to 27 October 19 48  
 and that I last saw him alive on 27 October 19 48

Immediate cause of death... hemorrhage, gastrointestinal  
 DURATION... 3 days

Due to... Cirrhosis of liver, atrophic Unknown

Due to... Carcinoma of bladder Unknown

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op.

Autopsy results... confirmed above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury... Injured at work?

23. SIGNATURE... Wm. A. DINSMORE, Jr. LCDR MC USN  
M. D. or other  
USNH Bethesda, Md. 10-28-48  
 Address... Date signed

RECEIVED  
NOV 1 1948  
BUREAU A. B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

186a

10664

Reg. Dist. No. 223

### 1. PLACE OF DEATH:

County Montgomery  
City or town Takoma Park, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 64 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County

City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)

Street No. apt 625-2480 16th St. N.W.

(If rural, give LOCATION)

2.(a) Is veteran, name war

### 3. (a) FULL NAME

Millie Cutler Vickery

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife William J. Vickery

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1862

8. AGE: Years 86 Months 6 Days 26 If less than one day hrs. min.

9. Birthplace Troy, Ind. Spencer County  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Thomas J. Cutler

13. Birthplace New York

14. Maiden name Mary Connor

15. Birthplace Virginia

16. Informant Hospital Records & Son

Address

17. Burial Removal Date thereof Oct. 31, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Eggsdale Indiana

18. Funeral director J. Hines Co

Address 2901-14th St

19. Nov. 1 48 Registrar

(Data rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 19 48 at 3:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 19 48 to Oct 31 19 48

and that I last saw him alive on Oct 31 19 48

Immediate cause of death Resp. failure

DURATION

Due to Fracture of hip

Due to Fracture of hip

Other conditions Arterial defect

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide acc. Date of 8/30/48

Where did injury occur? Wash. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Manner of injury Fall Injured at work?

23. SIGNATURE J. A. Henning M.D.

Address 28 Carroll Ave. Takoma Park, D.C.

Date signed 10/31/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7/11/48  
100-100000

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 10665 214

### 1. PLACE OF DEATH:

Country 6 Wetherall Rd

City or town Seven Springs  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

NONE  
NONE

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD.

County Montgomery

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6-Wetherill Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Elizabeth

Wagenet

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

RUSSELL WAGENET

7. Birth date of

deceased (mo., day, yr.)

JUNE 13

1890

6.(c) If alive, give age 58 years

8. AGE:

Years

Months

Days

If less than one day

58

hrs.

min.

9. Birthplace

Jacoma Wash

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER  
FATHER

12. Name

James Morrison

13. Birthplace

Oakland, Calif.

14. Maiden name

Margaret Herrick

15. Birthplace

Joseph Kansas

16. Informant

Russell Wagenet

Address

6 Wetherall Rd

17. Cremation

Fort Lincoln

Date thereof

Oct. 1, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

S H Hines Co

18. Funeral director

2901 14th St NW

Address

2901 14th St NW

19. Oct 4

19 48 Josephine Schaeffer

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 4/48

19 48

at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940

19

to Oct 4/48

19 48

and that I last saw her alive on Oct 4/48

19 48

Immediate cause of death

Coronary Occlusion

DURATION

3 1/2 hrs

Due to

Coronary Sclerosis

Due to

Other conditions

L

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W B Lins

M. D. or other

Address

1746 - K S H N W

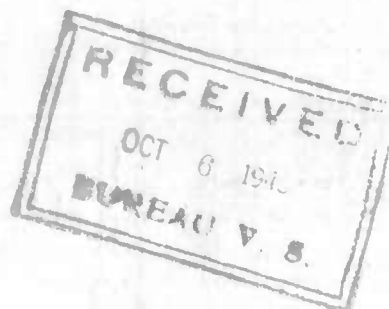
Date signed 10/4/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CO 7023

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10666

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

## 1. PLACE OF DEATH:

County Montgomery  
 City or town Olney, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.How long in hospital or institution? 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery  
 City or town Rockville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Bridge Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mr. Andrew A. Watkins

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married.6. (b) Name of husband or wife Mrs. Cecile Watkins

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 24, 1882

8. AGE: Years 66 Months 5 Days 25 If less than one day  
 hrs. min.

9. Birthplace Michigan  
 (Town, county, and state)

10. Usual occupation Shoe repairman.

11. Industry or business

12. Name Andrew Watkins13. Birthplace Michigan14. Maiden name Fannie Seavers15. Birthplace Michigan16. Informant Hospital records.

Address

17. Burial Date thereof Oct 22 1948  
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Rockville UnionLocation Rockville, Md.18. Funeral director Mrs. Gertrude HumphreyAddress Baltimore - Md.Date Oct 19 - 1948 by Registrar Gertrude B. Laver

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1948 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 11 1948 to October 19 1948

and that I last saw him alive on October 19 1948

Immediate cause of death Acute myocarditis DURATION 2 days

Due to Chest injury of chest 7 days

Due to Automobile Accident, pubis 7 days  
Fracture of symphysis pubis 7 days

Other conditions Hypertensive Cardis-vascular ? Years  
disease - previous Cardiac insufficiency 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 10-11-48Where did injury occur? Dairy Howard md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Auto accident Injured at work? no23. SIGNATURE Isaac J. Barrett M.D.

M. D. or other

Address Gaithersburg md Date signed 10-19-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



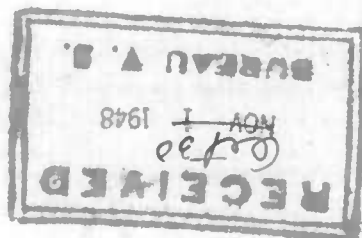
Box 46 Ned 10/23/

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE





Evidence to change birth  
date and age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10668

FILE No. G 11 OCT 22 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County Montgomery  
City or town Bethesda, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 mo. 11 days  
Hospital, institution, or street address where death occurred:  
US Naval Hospital, Bethesda, Maryland  
How long in hospital or institution? 3 mo 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County P.G.  
City or town Mount Ranier  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4201 Russell Ave  
(If rural, give LOCATION)  
2.(a) If veteran, name war Army 1920 to 1921 ✓

3. (a) FULL NAME

WILLS, Edward (n)

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of ~~husband~~ or wife Martha K Wills

7. Birth date of deceased (mo., day, yr.) 9 May 1925 1902 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 46 Months 3 Days 27 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
(Town, county, and state)

10. Usual occupation Postal Clerk

11. Industry or business

12. Name James Wills deceased

13. Birthplace England

14. Maiden name Henrietta Wagner deceased

15. Birthplace Germany

16. Informant Mrs Martha K Wills (wife)

Address 4201 Russell Ave Mt Ranier Md.

17. Burial Date thereof 10-11-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington Virginia

18. Funeral director H. S. HINES

Address 2901 14th St NW Washington D.C.

19. 10-6 18 48 Mary C. Patterson  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 October 48 2:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 June 19 48 6 October 19 48  
and that I last saw him alive on 6 October 19 48

Immediate cause of death Meningioma of brain

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Meningioma of brain

Date of op. 10-4-48

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John C. McNerney CDR MC USN M. D. or other \_\_\_\_\_

Address US Naval Hospital Date signed 10-6-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
OCT 12 1948  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARGIN RESERVED FOR BINDING

9-4.5-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

10669

RECEIVED

OCT 23 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

10670

216

## 1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since Oct. 21, 1948Hospital, institution, or street address where death occurred: Suburban Hospital8600 Old Georgetown Rd. Bethesda Md.How long in hospital or institution? Since Oct. 21, 1948

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P.G.City or town Huttsville Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.R. I - Morgan Nursing Home  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Mrs Lena C. Yeager

4. Sex

F

5. Color or race

Wh6. (1) Single, married, widowed, or divorced6. (b) Name of husband or wife James F. Yeager7. Birth date of deceased (mo., day, yr.) Oct. 16, 1869

6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day

7911

hrs.

min.

9. Birthplace Easton Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles Rigby13. Birthplace Easton Md.14. Maiden name Austin15. Birthplace Easton Md.16. Informant James F. Yeager

Address

17. Burial Date thereof Oct 30, 1948  
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Oct 27 19 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1948 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 20 1947 to October 27 1948and that I last saw her alive on October 26 1948Immediate cause of death EMBOLISM  
TO BRAIN AND SPLEEN

DURATION

Due to VEGETATIONS ON  
MITRAL VALVESDue to BACTERIAL ENDOCARDITIS OLD AND  
RECENTOther conditions INFARCTION OF  
SPLEEN

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results ACUTE AND CHRONIC ENDOCARDIAL  
PHYSICIAN: Please underline the cause to which death should be charged statistically. HEART

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Caron H. Traub M.D.Address 8230 Georgia Ave Silver Spring Md. Date signed 10/27-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

